PIERCING THE VEIL: THE LIMITS OF BRAIN DEATH AS A LEGAL FICTION

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Brain death is different from the traditional, biological conception of death. Although there is no possibility of a meaningful recovery, considerable scientific evidence shows that neurological and other functions persist in patients accurately diagnosed as brain dead. Elsewhere with others, I have argued that brain death should be understood as an unacknowledged status legal fiction. A legal fiction arises when the law treats something as true, though it is known to be false or not known to be true, for a particular legal purpose (like the fiction that corporations are persons). Moving towards greater transparency, it is legally and ethically justifiable to use this fiction to determine when to permit treatment withdrawal and organ transplantation.

However, persistent controversy and recent conflicts between hospitals and families over the treatment of brain-dead patients demonstrate the need for clearer limits on the legal fiction of brain death. This Article argues that more people should recognize that brain death is a legal fiction and further contends that existing scholarship has inadequately addressed the appropriate use of the legal fiction of brain death in legal conflicts.

For instance, as in Jahi McMath's case (in which a mother wanted to keep her daughter on a ventilator after she was determined brain dead), families may distrust physicians and hospitals who fail to acknowledge that brain death is a legal fiction. Legislators in most states have ignored the need to permit statutory exceptions for individuals with strong sanctity of life views. When hospitals treat brain-dead pregnant women, as in Marlise Muñoz's case, courts have failed to weigh the fundamental constitutional rights of pregnant women against the state's interests.

Finally, judges and legislators should sometimes "pierce the veil" of brain death and should not use the legal fiction in cases involving: (1) religious and moral objections, (2) insurance reimbursement for extended care of brain-dead patients, (3) maintenance of pregnant, brain-dead women, and (4) biomedical research. The

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Article concludes with general guidance for judges, legislators, and other legal actors to use regarding legal fictions.

INTRODUCTION

Considerable public attention has centered on two cases, in which hospitals and family members have disagreed over the treatment of brain-dead patients.[1] These cases demonstrate that the controversy over brain death cannot remain confined to scholarly literature[2] and that clearer guidance is needed regarding when brain death should or should not be used to resolve legal controversies.

Brain death is defined as the "irreversible cessation of all functions of the entire brain."[3] Notwithstanding the tremendous value of the legal standard of brain death in some contexts, "brain death" is simply not the equivalent of a traditional, biological conception of death where the heart stops beating and the body grows cold to the touch and begins deteriorating.[4] Although brain-dead patients are in an irreversible coma and have no chance of regaining consciousness or the ability to breathe spontaneously, they are not biologically dead. Their hearts still beat with the aid of mechanical ventilation; their bodies can heal wounds, mount stress responses, grow feverish in response to infection, move spontaneously, and maintain a warm body temperature; and, for many brain-dead patients, the brain continues to secrete vasopressin, a hormone that regulates the balance of salt and fluids in the body.[5]

Jahi McMath's case received national attention. Three physicians examined Jahi, a thirteen-year-old girl, a few days after she had surgery to remove her tonsils, adenoids, and uvula; these physicians

1. *See generally* Benedict Carey & Denise Grady, *At Issue in 2 Wrenching Cases*, N.Y. TIMES, Jan. 9, 2014, at A1; Manny Fernandez & Erik Eckholm, *Pregnant, and Forced to Stay on Life Support*, N.Y. TIMES, Jan. 7, 2014, at A1; Carolyn Jones & Henry K. Lee, *Brain-dead Jahi McMath released to her family*, S.F. GATE (Jan. 6, 2014), http://www.sfgate.com/health/article/Brain-dead-Jahi-McMath-released-to-her-family-5116262.php; Jason Wells, *Jahi McMath: Family of brain dead girl keeping out of public view*, L.A. TIMES (Jan. 14, 2014), http://www.latimes.com/local/lanow/la-me-ln-jahi-mcmath-family-brain-dead-body-20140114story.html.

2. *See, e.g.*, Michael Nair-Collins, *Brain Death, Paternalism, and the Language of "Death,"* 23 KENNEDY INST. ETHICS J. 53, 53 (2013).

3. UNIF. DETERMINATION OF DEATH ACT § 1 (1980), 12A U.L.A. 781 (2008).

4. Throughout this Article, the term "biological death" refers to the irreversible cessation of the functioning of an organism as a whole. *See* FRANKLIN G. MILLER & ROBERT D. TRUOG, DEATH, DYING, AND ORGAN TRANSPLANTATION: RECONSTRUCTING MEDICAL ETHICS AT THE END OF LIFE 69 (2012).

5. *See* D. Alan Shewmon, *The Brain and Somatic Integration*, 26 J. MED. & PHILOS. 457, 467–69 (2001).

agreed that she was brain dead.[6] The family believed that Jahi was alive and could still recover, and asked the hospital to keep her on the ventilator.[7] The family's lawyer expressed that the family did not believe that Jahi had died or that the hospital should treat her as a dead person because, with the support of mechanical ventilation, her heart was still beating and her body remained warm to the touch.[8] The family sought to compel the hospital to perform a tracheostomy on Jahi and insert a feeding tube to make it easier to transfer her to a local facility; the hospital refused.[9] The court initially issued a temporary restraining order against the hospital.[10] The court then required an independent physician to examine Jahi to determine whether she was brain dead, ultimately accepted the physician's determination of brain death, and considered Jahi legally dead.[11] The family eventually transferred her to a long term care facility.[12]

In the second case, Marlise Muñoz, who was fourteen weeks pregnant, suffered from what appeared to be a pulmonary embolism, and doctors determined she was brain dead in November 2013.[13] Although her family wished to remove her from life support and felt this was consistent with her wishes, the hospital refused. It cited a Texas law that states that "life-sustaining treatment" cannot be withdrawn or withheld from a pregnant woman, regardless of how

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6. Jones & Lee, *supra* note 1.

7. *Id.*

8. *Id.*

9. *Id.*; Carolyn Jones, *Jahi McMath's family says hospital blocking transfer*, S.F. GATE, (Dec. 31, 2013), http://www.sfgate.com/bayarea/article/Jahi-McMath-s-family-says-hospital-blocking-5105627.php.

10. Winkfield v. Children's Hosp. Oakland, Case No. RG13-07598 (Cal. Super. Ct. Dec. 20, 2013), (Temp. Restraining Order Following Petition for Emergency Protective/ Restraining Order Authorizing Medical Treatment and Authorizing Petitioner to Give Consent to Medical Treatment.), *available at* http://www.thaddeuspope.com/images/Winkfield_v._Childrens_Hosp_Oakland_Cal_2013_.pdf.

11. Lisa Fernandez, *Judge Declares Oakland Teen Legally Dead*, NBC BAY AREA, http://www.nbcbayarea.com/news/local/Third-Doctor-Declares-Jahi-McMath-of-Oakland-Legally-Dead-237179681.html.

12. Natalie Neysa Alund, *Jahi McMath: Timeline of events in case of brain-dead Oakland teen*, SAN JOSE MERCURY NEWS, http://www.mercurynews.com/nation-world/ci_24852090/jahi-mcmath-timeline-events-case-brain-dead-oakland; *Jahi McMath arrives at long-term care facility, says family*, CBS NEWS (Jan. 6, 2014), http://www.cbsnews.com/news/jahi-mcmath-arrives-at-long-term-care-facility/. Recent reports suggest that Jahi McMath is still maintained on a ventilator at this long-term care facility. Kristin J. Bender, *Jahi McMath still hooked to machines 1 year later*, S.F. GATE (Dec. 14, 2014), http://www.sfgate.com/news/us/article/Jahi-McMath-still-hooked-to-machines-1-year-later-5952198.php.

13. Manny Fernandez, *Texas Woman Is Taken Off Life Support After Order*, N.Y. TIMES, Jan. 26, 2014, at A9.

far along the pregnancy has advanced.[14] The family sued the hospital, arguing that the statute requiring hospitals to keep pregnant patients on life support should not apply to Ms. Muñoz because Texas law considers a person biologically dead when they are brain dead.[15] Although the court ultimately accepted this argument and granted the family's request,[16] a strict application of the legal fiction of brain death could have led to a different outcome under even slightly varied circumstances.

Because brain death is actually a legal fiction, courts should not, by default, extend the legal standard of brain death to the types of cases discussed above. A legal fiction exists when the law treats something known to be false (or not known to be true) as if it were true for a particular legal purpose.[17] Fictions are devices that simplify the extension of the law. For example, although corporations are not persons, the law treats them as such to apply statutes and case law to their circumstances. Moreover, courts are aware that sometimes exceptions to this legal fiction are warranted and have "pierced the corporate veil" when the strict application of the legal fiction would produce an unjust outcome.[18] Unlike the fiction of corporate personhood, however, the legal fiction of brain death is not widely acknowledged, which makes it hard to recognize when the courts use the legal fiction inappropriately. As a result, scholars, courts, and legislators have not addressed the need to limit the legal fiction of brain death. Important and valid uses of the legal fiction of brain death exist, for example determining when to withdraw life-sustaining therapy and allow organ donation. In contrast, using the traditional, cardiopulmonary standard for death, instead of the legal fiction of brain death, is important in some circumstances.

In light of scientific evidence, the existing rationales for considering brain death as a type of biological death fail.[19] Although commentators argue that it is indisputable that brain death is equivalent to biological death,[20] asserting this as a fact and ignoring

14. *Id.*

15. Fernandez & Eckholm, *supra* note 1; Diane Jennings, *Husband sues Fort Worth hospital to remove pregnant wife from life support*, DALLAS MORNING NEWS (Jan. 14, 2014), http://www.dallasnews.com/news/metro/20140114-husband-sues-fort-worth-hospital-to-remove-pregnant-wife-from-life-support.ece.

16. *See* Muñoz v. John Peter Smith Hosp., No. 096-270080-14 (Tex. 96th Dist. Ct. Jan. 24, 2014), *available at* http://www.thaddeuspope.com/images/MUNOZ_-_Stipulation_Facts.pdf.

17. *See* LON FULLER, LEGAL FICTIONS 9 (1967).

18. Robert B. Thompson, *Unpacking Limited Liability*, 47 VAND. L. REV. 1, 3 (1994).

19. *See* D. Alan Shewmon, *supra* note 5.

20. *See, e.g.*, Lawrence O. Gostin, *Legal and Ethical Responsibilities Following Brain Death: the McMath and Muñoz Cases*, 311 J. AM. MED. ASS'N 903, 903 (2014). Gostin argues that "[t]he

the existing controversy over brain death is problematic. For instance, some argue that because brain death is the same as death, physicians should never treat a brain-dead patient.[21] Yet physicians regularly treat brain-dead patients to keep their organs viable for organ donation.[22]

Perhaps because our medical and legal discourse employs the term "death" when it refers to "brain death" and "biological death," the important distinctions between these two states are overlooked. When theorists believe the law treats brain-dead and biologically-dead individuals identically, relevant considerations are omitted from medical and legal discourse. The hospital's reluctance to accommodate the McMath family illustrates this point. It was not clear whether California's statute, requiring some brief period of accommodation to allow family to gather at the bedside of a brain dead patient,[23] generated any legal obligation on the hospital to respect the family's views and to facilitate the transfer of Jahi McMath to another facility.

The under-acknowledged distinction between biological death and brain death causes confused reasoning and potentially problematic outcomes. In certain legal contexts, a traditional conception of cardiopulmonary death, rather than brain death, aligns better with the law's underlying goals and policy. For instance, although the correct outcome was reached in *Muñoz*, as argued *infra*, given the complexity of the issues involved and the potentially conflicting rights and interests of the mother and fetus, hospitals and physicians should not use the brain death standard mechanically to justify terminating treatment. Instead, they should weigh a woman's constitutional rights to privacy and to consent to treatment against the state's interest in preserving her life and the life of her fetus. Furthermore, judges and legislators engaged in this balancing should take into account the diminished interests of brain-dead individuals and recognize that states have reduced interests in preserving the lives of brain-dead individuals.

Simply stated, brain death is a useful construct in some cases. In other cases, a traditional, cardiopulmonary standard for death is

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McMath and Muñoz cases are quite distinct in that both of these individuals have been declared legally dead. Once a patient has died, any conversation about the appropriate form of medical treatment is no longer relevant. This would mean, for example, that while Jahi's mother could ask for ventilation for a short duration to enable her to come to terms with her daughter's death, the very idea of 'treatment,' especially if it is of an indefinite duration, would be well beyond the bounds of prevailing ethical or legal thought." *Id.*

21. *See, e.g., id.*

22. Pauline M. Todd et al., *Organ Preservation in a Brain Dead Patient: Information Support for Neurocritical Care Protocol Development*, 95 J. MED. LIBR. ASS'N 238, 238 (2007).

23. CAL. HEALTH & SAFETY CODE § 1254.4 (West 2008).

more appropriate. Therefore, resolving the question of when it is appropriate to use brain death as a legal fiction will increase transparency and awareness of the fiction's limits. The McMath and Muñoz cases demonstrate the need for a clearer understanding of when to use the legal fiction of brain death.

To develop this argument, Part I describes the historical development of brain death, the current legal standards for determining death, and the widely-accepted evidence about brain death that caused controversy. Part II explores the theoretical basis and justifications for legal fictions and establishes a theoretical approach to status legal fictions. This theoretical analysis demonstrates why using a legal fiction is the best solution to the controversy over brain death. Part III argues for greater transparency surrounding the legal fiction of brain death among judges, legislators, hospitals, and members of the public. That Part addresses the appropriate use of the legal fiction of brain death by using the cases of Jahi McMath and Marlise Muñoz. In particular, hospitals and courts should not use the legal fiction of brain death in cases involving: (1) religious and moral objections, (2) insurance reimbursement for extended care of brain-dead patients, (3) maintenance of pregnant, brain-dead women, and (4) biomedical research. Part IV discusses the implication of the analysis for legal actors deciding whether to create or use legal fictions. For these actors, in some cases, it is better not to employ legal fictions in the first place. When legal fictions are adopted and used, the doctrine should only be applied within appropriate limits. Finally, this Part proposes areas for future scholarship to explore the use of legal fictions in technological legislation and critically evaluates the general use of legal fictions.

I. BACKGROUND

A. The Historical Development of Brain Death

Death has long been associated with a body that is cold to the touch and without breath, heartbeat, or pulse. Of course, in the distant past, death was difficult to accurately determine. Concern about premature burials once prompted periods of high public anxiety about the determination of death.[24] Nevertheless, for much

24. JAN BONDENSON, BURIED ALIVE: THE TERRIFYING HISTORY OF OUR MOST PRIMAL FEAR 31–32 (2002) (documenting periods with high levels of anxiety among the public about the prospect of being buried alive, such as after cholera epidemics when the dead were buried hastily in order to avoid the spread of disease). Some contended that bodily decay was the only sure sign of death at the time.

of history, laypeople and the medical profession have believed that death occurs when breathing ceases and the heart stops beating permanently.[25] The legal view of death followed the medical one. The fourth edition of Black's Law Dictionary, published in 1968, defined natural death as "[t]he cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."[26]

With the development of ventilators and other life-sustaining technologies in the 1950s and 1960s, the implications of the traditional, cardiopulmonary view of death troubled physicians. Ventilators could maintain patients for years at a time, even though some of these patients seemed to have permanently lost consciousness, the ability to breathe spontaneously, and the ability to interact meaningfully with others.[27] French scientists first identified this state as "coma dépassé"[28] (roughly translating to "beyond coma").[29] Physicians and scientists came to believe that this state of profound neurological loss belonged in a category of its own. Legal, moral, or social reasons linked this category to a legal determination of death.[30]

In 1968, Henry Beecher and others from Harvard formed the self-described Ad Hoc Committee of the Harvard Medical School. The Committee published an article intended to change how death was determined, both legally and medically.[31] The article noted that new approaches to life-sustaining technology were placing considerable burdens on families and hospitals, and that people kept on ventilators could serve as a source of valuable, high-quality organs.[32]

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25. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH: MEDICAL, LEGAL, AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 5 (1981) [hereinafter PRESIDENT'S COMMISSION].

26. BLACK'S LAW DICTIONARY 488 (4th ed. 1968). *See also* Thomas v. Anderson, 96 Cal. App. 2d 371, 376 (Cal. Dist. Ct. App. 1950) (citing identical language in the third edition of Black's Law Dictionary).

27. MILLER & TRUOG *supra* note 4, at 53–54 (2012).

28. Pierre Mollaret & Maurice Goulon, *Le coma dépassé [The depassed coma (preliminary memoir)]*, 101 REV. NEUROL. (PARIS) 3 (1959).

29. THE PRESIDENT'S COUNCIL ON BIOETHICS, CONTROVERSIES IN THE DETERMINATION OF DEATH 3 (2008).

30. Calixto Machado et al., *The Concept of Brain Death Did Not Evolve to Benefit Organ Transplants*, 33 J. MED. ETHICS 197, 197–98 (2007). Note that although Machado and colleagues accurately describe the evolution of the concept of brain death, scientists and physicians did not necessarily view total brain failure as a new way of determining death at least until the publication of the Ad Hoc Committee report, if not later. *See id.* at 198.

31. Ad Hoc Committee of the Harvard Medical School, *A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 252 J. AM. MED. ASS'N 677, 677–78 (1984) [hereinafter Ad Hoc Committee].

32. *Id.*

Next, they proposed a new way to determine death, based on the permanent cessation of neurological functioning.[33] The Ad Hoc Committee also noted that if physicians could agree on a new way to determine death, they had the potential to effect profound legal change since physicians were typically asked to determine death in legal disputes.[34] However, the Committee did not justify their belief that the cessation of neurological activity, or "brain death," should be considered death.

An article published shortly after this report commented on the need for a public dialogue about the new criteria for death and cited data, suggesting that the public was very confused about the notion of brain death.[35] Although debate persisted, the issue was ultimately was somewhat resolved in the early 1980s. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (hereinafter, "President's Commission") was convened and tasked with explaining why patients who fit the Ad Hoc Committee's proposed neurological criteria should be considered biologically dead.[36] The President's Commission explained that the development of technologies to sustain life "masked" that death had already occurred and argued that death happened with the loss of integrative functioning of the organism as a whole.[37] They also proposed model language for a law that states could adopt to change the traditional way of determining death to include neurological criteria, or, in more colloquial terms, brain death.[38]

B. The Legal Standard for Determining Death

The model language proposed by the Presidential Commission was adopted in the Uniform Determination of Death Act (UDDA).[39] Forty-four states and the District of Columbia have adopted the UDDA.[40] The Uniform Law Commission described the UDDA's purpose as a "minimum one" that merely "recognizes cardiorespiratory and brain death in accordance with the criteria the

33. *Id.*
34. *Id.* at 338–39.
35. John D. Arnold et al., *Public Attitudes and the Diagnosis of Death*, 206 J. AM. MED. ASS'N 1949, 1953–54 (1968).
36. *See* PRESIDENT'S COMMISSION, *supra* note 25, at 1–12 (1981).
37. *Id.* at 33.
38. *Id.* at 2.
39. UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 780 (supp. 1991).
40. Eelco Wijdicks, *Brain Death Worldwide*, 58 NEUROLOGY 20, 21 (2002).

medical profession universally accepts."[41] The Uniform Law Commission also explained that the act purposefully left the means of determining death unspecified to ensure that the act did not become out-of-date as medical technology advanced.[42] Instead, the UDDA provides the following:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.[43]

Notwithstanding the widespread acceptance of the UDDA,[44] some variations persist. First, states have different "acceptable medical standards" for determining death.[45] The American Academy of Neurology provides helpful general guidance for clinicians.[46] The first task for a clinician to determine whether a patient is brain dead is to establish the coma's cause and rule out other potentially reversible causes (such as hypothermia and drug use).[47] Then, the clinician should perform a series of tests to detect whether any neurological reflexes are still present.[48] These tests include shining a light in both eyes and detecting no change in pupil size; touching the cornea with a piece of tissue paper, a cotton swab, or squirts of water and seeing no eyelid movement; and confirming the inability to breathe independently with a process that includes taking the patient off the ventilator for several minutes.[49] States' requirements vary as to whether the physician making the determination must

41. Uniform Law Commission, Determination of Death Act Summary, http://www.uniformlaws.org/ActSummary.aspx?title=Determination%20of%20Death%20Act (last visited Sept. 21, 2014).

42. *Id.*

43. UNIF. DETERMINATION OF DEATH ACT *supra* note 39, at 780.

44. PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 5–6 (2008).

45. *See, e.g.*, VA. CODE. ANN. § 54.1-2972 (2013) (requiring that two specialists in "neurology, neurosurgery, electroencephalography, or critical care medicine" certify brain death); CAL. HEALTH & SAFETY CODE § 7181 (West 1982) (requiring "independent confirmation" by a physician); FLA. STAT. § 382.009(b) (2014) (requiring that two physicians make the determination and that "[o]ne physician shall be the treating physician, and the other physician shall be a board-eligible or board-certified neurologist, neurosurgeon, internist, pediatrician, surgeon, or anesthesiologist.").

46. *See generally American Academy of Neurology Guidelines for Brain Death Determination*, LIFE ALLIANCE ORGAN RECOVERY AGENCY, http://surgery.med.miami.edu/laora/clinical-operations/brain-death-diagnosis (last visited Sept. 7, 2014).

47. *Id.* at § I.

48. *Id.*

49. *Id.*

have specialized in neurology, how many physicians have to conduct these tests, and whether registered nurses may participate in making the determination of death.[50] Some states have requirements for the specialty of the physician performing the examination based on the patient's age, and some state statutes are more detailed than others and delineate the clinical findings that indicate brain death has occurred.[51]

State laws also vary with respect to whether they accommodate religious or moral objections to brain death. Two states, New York and New Jersey, allow for exceptions in cases where individuals have religious views that do not accept brain death as biological death. New Jersey's statute first describes how death is determined in terms that are more consistent with a legal fiction: "[A]n individual whose circulatory and respiratory functions can be maintained solely by artificial means, and who has sustained irreversible cessation of all functions of the entire brain, including the brain stem, shall be declared dead."[52] The statute then indicates the appropriate use of cardiopulmonary criteria for people who have religious objections to brain death:

> The death of an individual shall not be declared upon the basis of neurological criteria . . . when the licensed physician authorized to declare death, has reason to believe, on the basis of information in the individual's available medical records, or information provided by a member of the individual's family or any other person knowledgeable about the individual's personal religious beliefs that such a declaration would violate the personal religious beliefs of the individual. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria.[53]

New York has adopted the UDDA, but it requires hospitals to include "a procedure for the reasonable accommodation of the individual's religious or moral objection to the determination as expressed by the individual, or by the next of kin or other person closest to the individual."[54] Since 2009, California has also required hospitals to provide a "reasonably brief period of accommodation"

50. Wijdicks, *supra* note 40.
51. *See, e.g.*, N.J. ADMIN. CODE § 13:35-6A.1 et seq.
52. N.J. Declaration of Death Act, N.J. STAT. ANN. 26:6A-3 (West 1991). This language is consistent with a legal fiction because the statute does not state that such an individual "is dead" and merely indicates that the individual "shall be declared dead."
53. *Id.* at 6A-5.
54. Determination of Death, N.Y. COMP. CODES R. & REGS. tit. 10, § 400.16(a)(2) (1987).

that allows families or next of kin to gather at the bedside.[55] Moreover, if a surrogate decision-maker or family member voices religious or cultural concerns about brain death, the hospital must "make reasonable efforts to accommodate those religious and cultural practices and concerns."[56] The hospital is only required to continue to provide cardiopulmonary support and may also consider other patients' needs.[57] Brain death and cardiopulmonary death are now the two legal standards for determining death in the United States and in many international jurisdictions.[58]

C. Criticisms of Using Neurological Criteria to Determine Death

Some scholars, and even the members of the Harvard Ad Hoc Committee themselves, were uneasy with the concept of brain death from the beginning.[59] D. Alan Shewmon's work, which emerged in the late 1990s, contained the most forceful challenge. Shewmon demonstrated that some patients, whom doctors had accurately determined to be dead under neurological criteria, could perform functions that seemed to require a body with integrative functioning[60] and which the President's Commission would have called alive.[61] These functions included wound healing, spontaneously moving, maintaining a warm body temperature (though one was a few degrees below normal), mounting stress responses, and fighting infections.[62] Many brain-dead patients still have at least one functioning part of the brain—the hypothalamus, which continues to secrete vasopressin through the posterior pituitary.[63] Rare cases

55. CAL. HEALTH & SAFETY CODE § 1254.4 (West 2008).
56. *Id.* at (c)(2).
57. CAL. HEALTH & SAFETY CODE § 1254.4(d) (West 2008).
58. Wijdicks, *supra* note 40. Internationally, there is a divide between the "whole brain death" standard used in the U.S. and the "brainstem death" standard created in the U.K. and also used in countries such as Canada and India. C. Pallis, *ABC of Brain Stem Death. The Position in the USA and Elsewhere*, 286 BR. MED. J. 209, 209 (1983). The brainstem is the part of the brain that connects to the spinal cord and controls many important, involuntary bodily functions, such as breathing and swallowing. Some U.K. clinicians argue that this difference has little practical significance because injury affecting only the brainstem is rare, and the clinical examination used is "virtually identical around the world." *See, e.g.*, D. Gardiner et al., *International Perspective on the Diagnosis of Death*, 108 Suppl 1 BR. J. ANAESTH. i14, i19, i25 (2012).
59. Martin S. Pernick, *Brain Death in a Cultural Context: The Reconstruction of Death, 1967–1981*, *in* THE DEFINITION OF DEATH: CONTEMPORARY CONTROVERSIES 9 (Stuart J. Younner et al. eds., 1999) (discussed at greater length in *infra* Part II.B).
60. Shewmon, *supra* note 5, at 459–69.
61. PRESIDENT'S COMMISSION, *supra* note 25.
62. *Id.*
63. *See* Kazunori Arita et al., *The Function of the Hypothalamo-Pituitary Axis in Brain Dead Patients*, 123 ACTA NEUROCHIRURGICA 64, 66–71 (1993); *see also* Michael Nair-Collins et al.,

have occurred in which pregnant brain-dead patients successfully gestated fetuses[64] and children even underwent puberty.[65]

This evidence undermines the view that brain death is equivalent to biological death and the idea that integration of the body stops with the advent of brain death. First, many brain-dead patients do not lose all neurological function, as the UDDA and state laws explicitly require to determine brain death.[66] Second, the rationales that justify construing brain death as biological death fail. The President's Commission argued that death occurs when the body's integrative functioning ceases;[67] yet, as discussed above, integrative functioning does not necessarily stop upon brain death. For instance, it seems strange to say that brain-dead women who gestated fetuses for months at a time, which requires extensive biological activity across different organ systems, had lost integrative functioning. The fact that brain death is not equivalent to biological death is important because it creates problems for legal standards that are premised upon, and incorporate, a brain death standard.

One could argue that integrative functioning does not matter because brain-dead patients rely on mechanical ventilation to perform these functions. Along those lines, the President's Commission argued that life-sustaining technology merely serves to "mask" the presence of death.[68] However, other instances exist in which technology is necessary to preserve organ function in people, and they are not considered anywhere close to death. Examples include individuals who rely on pacemakers to keep their hearts beating or patients who require dialysis. Without mechanical intervention, these patients would not be alive, yet they are not considered dead or even terminally ill.

Scholars, including the diverse group of scholars who formed the President's Council on Bioethics under President George W. Bush, almost universally accept that some neurological and integrative

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Hypothalamic-Pituitary Function in Brain Death: A Review, J. INTENSIVE CARE MED. 4–5 (March 30 2014), http://jic.sagepub.com/content/early/2014/03/29/0885066614527410.abstract.

64. David J. Powner & Ira M. Bernstein, *Extended Somatic Support for Pregnant Women after Brain Death*, 31 CRIT. CARE MED. 1241, 1241–42 (2003).

65. Shewmon, *supra* note 5, at 468.

66. D. Alan Shewmon, *Brain Death or Brain Dying?* 27 J. CHILD NEUROL. 4, 5 (2012). It is an open question whether all brain dead patients maintain some form of integrative functioning, or whether it is just some subset of brain dead patients who could, theoretically, be identified if there were more accurate criteria for determining which patients are truly brain dead. Shewmon describes his cases in a way that could be consistent with this explanation. Yet he and others have published many cases of patients who still have some integrative and/or neurological functioning and people who fit existing criteria for determining brain death. *See, e.g.*, Powner & Bernstein *supra* note 64, at 1241; Nair-Collins et al., *supra* note 63.

67. *See* PRESIDENT'S COMMISSION, *supra* notes 25, 36–38 and accompanying text.

68. PRESIDENT'S COMMISSION, *supra* note 25, at 5–6.

functioning continues in some patients after an accurate diagnosis of brain death.[69] In December 2008, the President's Council acknowledged that this evidence required a reexamination of the neurological criteria for death and of the justification for why patients who fulfill those criteria are considered dead.[70]

The President's Council coined the phrase "total brain failure" to refer to the physiological state of those patients without calling them dead.[71] The President's Council noted that Shewmon and others' research left them with two options: (1) to decide that society must abandon neurological criteria for determining death or (2) to develop a new rationale to explain why neurological criteria should determine death.[72] A majority of the Council rejected the first option, noting that this would require halting the life-saving practice of organ transplantation and endeavored to develop a new rationale for determining death.[73]

The Council argued that an organism is no longer alive when it ceases to perform the "fundamental vital *work* of a living organism—the work of self-preservation, achieved through the organism's need-driven commerce with the surrounding world."[74] They explained that the following features characterize this work: (1) "[o]penness to the world," (2) "[t]he ability to act upon the world" to fulfill one's needs, and (3) a felt need that drives action to obtain what one needs.[75] The Council stated that breathing and consciousness are the two primary ways of demonstrating that work.[76]

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69. *See* PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 40.

70. *Id.*

71. *Id.* at 12. The Council qualifies their definition of total brain failure by explaining that it does not preclude the existence of islands of brain tissue that may be damaged but not completely deteriorated. Additionally, some functionality is retained in the majority of patients diagnosed with "brain death"—they continue to secrete anti-diuretic hormone, a process that the brain mediates. *Id.* at 37–38. Thus, there remains some, perhaps very minimal, brain function in patients with total brain failure. Notably, the Council claims they are relying on an approximation of total brain failure, which is different than the target of this paper—treating whole brain death as biological death.

72. Notably, the Council explains elsewhere that if total brain failure cannot support a definition of death, it would not endorse abandoning the dead donor rule and allowing organ transplantation to proceed. *Id.* at 11–12. The members also explain that total brain failure does not necessarily mean complete failure—isolated parts of the brain may still function. They claim that the relevant question, however, is the following: "*Is the organism as a whole still present*?" *Id.* at 38.

73. *Id.* at 58; *see also id.* at 95–100 (personal statement of Alfonso Gómez-Lobo, Ph.D., arguing against abandoning existing criteria for death).

74. *Id.* at 60.

75. *Id.* at 61.

76. *See id.*

Some have praised the Council's report for straightforwardly acknowledging evidence about brain death in scientific literature.[77] Nevertheless the report did not meet the Council's stated goals. First, the term "total brain failure" is inaccurate; patients who are accurately diagnosed as brain dead continue to have certain brain functions.[78] Second, the Council failed to produce a defensible rationale for sufficiency of neurological criteria for determining death. Wound healing, fighting off infections, and stress responses to an incision to remove organs (without anesthesia) are all reactions to the environment and a way to express a need for self-preservation.[79] Thus, the Council's rationale should consider patients with total brain failure alive, not dead.

Moreover, as Shewmon notes, the Council's definition is over-inclusive.[80] Its rationale would consider fetuses relatively early in development dead because they do not breathe and do not have consciousness.[81] Although there is controversy over whether a fetus is a person,[82] no one disputes that fetuses are alive. The Council could, of course, consider fetuses early in development alive and state that it determines fetal death differently than and disconnected from how it determines death for born people and for animals. Determining death for fetuses according to different criteria than other humans, however, seems implausible. Finally, the Council's reasoning does not hold up to scrutiny.[83] Despite the Council's failure, a more fruitful way of thinking about brain death exists—namely as a legal fiction.

II. A LEGAL FICTION VIEW OF BRAIN DEATH

Although two U.S. presidential bioethics boards have asserted that brain death is not a legal fiction,[84] thinking of brain death as a

77. *See, e.g.*, D. Alan Shewmon, *Brain Death: Can It Be Resuscitated?*, 39 HASTINGS CENTER REP. 18, 19–20, 23 (2009).

78. Shewmon, *supra* note 5, at 465; *see generally* Amir Halevy, *Beyond Brain Death?*, 26 J. MED. & PHIL. 493 (2001).

79. *See* PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 56.

80. Shewmon, *supra* note 77, 20–21.

81. *Id.* at 22.

82. *See, e.g.*, Gregory J. Roden, *Unborn Children as Constitutional Persons*, 25 ISSUES L. & MED. 185 (2010).

83. Seema K. Shah & Franklin G. Miller, *Can We Handle the Truth? Legal Fictions in the Determination of Death*, 36 AM. J.L. & MED. 540, 550–51 (2010) (noting that the Council recognizes that a person who has permanently lost consciousness can be alive, and a person who cannot breathe without mechanical support can be alive, but then concludes, without explaining why, that a person who lacks both of these abilities is dead).

84. PRESIDENT'S COMMISSION, *supra* note 25, at 31; PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 49–50. In the body of the report, the Council explicitly rejects the notion

legal fiction clarifies much of the theoretical confusion surrounding brain death. Brain death is an unacknowledged status legal fiction.[85] The legal fiction of brain death is ethically justifiable for the purpose of permitting patients to consent to organ transplantation, provided its continued use comes with increased public awareness about the fiction's existence.[86] In some, but not all, cases there are good reasons to justify using the legal fiction of brain death, but it is important to be explicit that it is a legal fiction.

A. Defining Legal Fictions

To understand the argument about brain death as a legal fiction, it is essential to understand the general concept of a legal fiction and the motivations behind the creation of legal fictions. This Subsection will first explain and then apply those basic concepts to the legal fiction of brain death.

A legal fiction is a somewhat counterintuitive device that relies on falsehoods to extend the law into new areas. Legal fictions arise when the law treats something that is false (or not known to be true) as if it were actually true. Sir Henry Maine noted that fictions first arose in Roman law, usually to expand the jurisdiction of a court and to ensure that the court had authority to try certain lawsuits.[87] The first legal fictions involved statements that plaintiffs could make that defendants were not allowed to counter.[88] For example, a plaintiff could allege he was a Roman citizen, even if he was a foreigner, in order to allow him to bring suit in a Roman court.[89]

Lon Fuller built on this work and more concretely defined a legal fiction in his canonical work on the subject. According to Fuller, a legal fiction is "either (1) a statement propounded with a complete or partial consciousness of its falsity, or (2) a false statement recognized as having utility."[90] Although Blackstone recognized the value

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that "death should be treated merely as a legal construct or as a matter of social agreement." *Id.* at 49. Meilaender argues that "[t]he Council rejects the view that the criteria for determining death should be shaped or determined by our need and desire for transplantable organs. We should not create 'legal fictions' or 'social agreements' whose aim is less an accurate determination of death than a ready supply of organs. Whatever else human beings may be, they are living bodies, and their death is a biological reality that we need to mark as accurately as we are able." *Id.* at 103 (personal statement of Gilbert C. Meilaender).

85. Shah & Miller, *supra* note 83, at 559–64.
86. *Id.* at 569–71.
87. HENRY MAINE, ANCIENT LAW (1861).
88. *Id.*
89. *Id.*
90. FULLER, *supra* note 17 at 9.

of legal fictions,[91] others have argued that fictions were vestigial elements of law that interfered with symmetry and orderliness.[92]

A threshold question is whether there exists a difference between a "legal fiction" and a situation in which the legal definition of a term differs from the ordinary use of it. There are at least two important differences between the standard approach to legal definitions and the creation of a legal fiction.

First, legal fictions may involve treating something that does not obviously fit (and perhaps would not usually be treated as if it fit) into a particular category as if it belonged to that category.[93] For instance, it is not obvious that one should to treat a corporation the same as a person. Even though people make up corporations, corporations do not have many fundamental characteristics of persons—they do not breathe, eat, or sleep. They do share some features of personhood, such as the ability to commit crimes or to be subject to civil liability. Thus, in some ways, it might make sense for the law to treat corporations as persons and in other ways not. Hence courts use the legal fiction of corporate personhood, along with the ability to pierce the corporate veil, as needed to capture this tension.

Second, legal fictions are different than other legal constructs because the person who makes the statement and who hears it both recognize its falsity. For instance, to obtain jurisdiction, one English court declared that the Isle of Minorca was located within London.[94] This extended the court's jurisdiction beyond its approved boundaries and was intended to fit Minorca into a category in which it did not belong. By contrast, deciding that a Segway is a "vehicle" in interpreting a statute that prohibits vehicles in a public park does not stretch a category beyond reasonable limits and is not easily construed as false.

Jeremy Bentham characterized legal fictions as instances in which judges have improperly engaged in legislating,[95] suggesting

91. 3 WILLIAM BLACKSTONE, COMMENTARIES *43 ("These fictions of law, though at first they may startle the defendant, he will find upon farther consideration to be highly beneficial and useful; especially as this maxim is ever invariably observed, that no fiction shall extend to work an injury; it's [sic] proper operation being to prevent a mischief, or remedy an inconvenience, that might result from the general rule of law.").

92. MAINE, *supra* note 87.

93. Shah & Miller, *supra* note 83 at 561–62.

94. FULLER, *supra* note 17. at 18 (citing JOHN CHIPMAN GRAY, THE NATURE AND SOURCES OF THE LAW 34 (1st ed. 1909)).

95. JEREMY BENTHAM, A COMMENT ON THE COMMENTARIES AND A FRAGMENT OF GOVERNMENT 509–10 (J.H. Burns & H.L.A. Hart eds., 1977) (1838) (describing a legal fiction as a "willful falsehood, having for its object the stealing legislative power, by and for hands, which could not, or durst not, openly claim it, and, but for the delusion thus produced, could not exercise it.").

that he did not think that legislators could create fictions. In contrast, Fuller thought judges or legislators could create legal fictions.[96] Statutory legal fictions are more puzzling than judicial fictions. Why would a legislator rely on a fiction when she or he could merely define the terms of the law to cover what she or he would like it to cover? Fuller explained that statutory legal fictions help simplify concepts or use familiar terms to extend the law.[97] He also noted that fictions are not necessarily created with a clear sense of their falsity and may just "imply the opinion that the author of the statement in question was (or would have been had he seen its full implication) aware of its inadequacy or partial untruth, although . . . he could think of no better way of expressing the idea he had in mind."[98] This type of situation appears especially applicable to judges or legislators, who create legal rules in territory that is unfamiliar to them, such as science and medicine. If the author of a fiction does not fully realize its fictive nature, moreover, the fiction is more likely unacknowledged and opaque.[99] Judges employ legal fictions for a number of different reasons.[100] Bright-line legal fictions involve drawing a boundary that is under- and over-inclusive to develop an easily administrated rule.[101] Anticipatory fictions treat something that will soon be true as if it were already true to avoid causing harm.[102] Aspirational fictions involve putting forth a standard that is desirable in the abstract but nearly impossible to achieve in practice.[103] A status legal fiction is an analogy in which one entity is treated as if it has the status of a different entity to

96. *See* FULLER, *supra* note 17, at 87–92.

97. FULLER, *supra* note 17, at 90 ("In accordance with the notion that the legislator 'commands' or is 'all-powerful,' it is often assumed that if fictions *are* found in legislation they are to be construed as expository devices—mere conveniences of expression.").

98. FULLER, *supra* note 17, at 8.

99. As Fuller explains: "The use of the word 'fiction' does not always imply that the statement's author positively disbelieved it. It may rather imply the opinion that the author of the statement in question was (or would have been had he seen its full implication) aware of its inadequacy or partial untruth, although he may have believed it in the sense that he could think of no better way of expressing the idea he had in mind." FULLER, *supra* note 17, at 8. Additionally, it is important not to confuse legal fictions with legal realist critiques of law. Lon Fuller was a part of the legal realist tradition. Lon L. Fuller, *American Legal Realism*, 82 U. PA. L. REV. 429, 443 (1934). However, his work on legal fictions diverges from his legal realist critiques because legal fictions are meant to be transparent devices to extend the law that have been openly recognized for centuries and not part of a more general skepticism of rules to challenge classical legal theory. Michael Stephen Green, *Legal Realism as Theory of Law*, 46 WM. & MARY L. REV. 1915, 1917 (describing legal realism as "rule-skepticism").

100. *See* Peter J. Smith, *New Legal Fictions*, 95 GEO. L.J. 1435, 1439–41 (2006).

101. Shah & Miller, *supra* note 83, at 560–61.

102. Shah & Miller, *supra* note 83, at 563.

103. Seema K. Shah, *Does Research with Children Violate the Best Interests Standard? An Empirical and Conceptual Analysis*. 8 NW. J.L. & SOC. POL'Y 121, 159 (2013).

justify applying an existing legal framework.[104] Status fictions are, by nature, analogies because the second entity is not actually an example of the first entity. Rather, one entity is simply treated as if it were another because the two are similar in ways that make the analogy sensible in order to administer the law.

For example, corporations are often treated as if they were people under the status legal fiction of corporate personhood. Because this legal fiction makes an analogy between the needs and activities of people and those of corporations, and many existing laws were created to regulate "persons," it is more convenient for administering existing laws to grant corporations the legal status of "person."[105] Our legal system is based upon prior authority, and analogical reasoning from existing legal authority is a valid and common way of extending law.

Another example of a status legal fiction is common law marriage, which some states recognize. Under the doctrine of common law marriage, two people who have never participated in a wedding ceremony or obtained a marriage license, but who live together and hold themselves out to be a married couple, are considered married under the law.[106] Additionally, the doctrine of substituted judgment arose through the use of a legal fiction in *Ex Parte Whitbread*, decided in the English Court of Chancery in 1816.[107] In this case, the Chancellor, Lord Eldon, was faced with administering a lunatic's estate (in English common law, a lunatic was a person who was competent at one time but became incompetent).[108] The man's niece petitioned for an allowance from the estate, which was beyond the scope of what the Court had the authority to permit.[109] Presumably moved by the niece's plight, Lord Eldon decided that the court was constrained to benefit the lunatic and that the only way to do that was to do what he would have wanted—even in the absence of any evidence of his prior wishes—thereby authorizing the court to give an allowance to his niece.[110]

104. Shah & Miller, *supra* note 83, at 561.

105. *See* State v. Std. Oil Co., 49 Ohio St. 137, 177 (1892) ("The general proposition that a corporation is to be regarded as a legal entity . . . is not disputed; but that the statement is a mere fiction, existing only in idea, is well understood . . . . It has been introduced for the convenience of the company in making contracts, in acquiring property for corporate purposes, in suing and being sued, and to preserve the limited liability of the stockholders, by distinguishing between the corporate debts and property of the company, and of the stockholders in their capacity as individuals.").

106. Peter Nicolas, *Common Law Same-Sex Marriage*, 43 CONN. L. REV. 931, 933–34 (2010) (noting the legal impossibility of divorce from common law marriage).

107. Louise Harmon, *Falling Off the Vine*, 100 YALE L.J. 1, 19 (1990).

108. *Id.* at 21.

109. *Id.* at 19.

110. *Id.* at 22.

One final example (perhaps one closer to the focus of this Article) is the legal fiction of "civil death." Black's Law Dictionary defines "civil death" as "the loss of rights—such as the rights to vote, make contracts, inherit, and sue."[111] Civil death was a legal device that allowed property to pass on to the heirs of people who became monks or those who renounced their right to remain a member of society by committing a serious crime.[112] The idea behind civil death was to treat someone who was clearly alive "as though he were naturally dead."[113]

Regarding the limits of status fictions, remember all analogies have limitations. Consider the use of legal precedent: lawyers representing clients rarely have a case that directly replicates the facts of a case that is binding precedent. Instead, the lawyer must argue from analogy, deciding which features of a case are relevant. The critical work involved in adjudicating legal disputes in common law legal systems is to determine which cases have features that are good analogies to the case at hand and which do not. If a case is not favorable to the client's interest, the lawyer may argue that the facts of the previous case are so different from the case at hand that the court should disregard it. No case will settle all future cases with the underlying subject matter, just as no analogy is ever perfect.

Thus, anyone using a legal fiction that relies on an analogy should note its limitations. The Supreme Court's decision in *Citizens United* possibly led to considerable controversy because people disagreed about the correct limits of the legal fiction of corporate personhood.[114] The majority opinion found that the law could not ban political speech merely because the speaker is a corporation, thereby clarifying that freedom of speech extends to corporations.[115] Other Justices thought that the court should not extend the legal fiction so far;[116] the treatment of a corporation as a person for civil liability purposes does not required treating it as such with regards to free speech law. If there were a clear way to determine

111. BLACK'S LAW DICTIONARY, 484 (10th ed. 2014).

112. *Id.*

113. *Id.* Note that there is also a common law fiction of "presumptive death," that is, declaring a person dead after he or she has been missing for seven years. Although this is possibly a type of bright-line fiction, where most people who have been missing for seven years are likely dead, it lends credence to the notion that death poses special definition problems for the law.

114. Floyd Abrams, Alan B. Morrison & Ronald K. L. Collins, *Transcript: Debate on Citizens United v. Federal Election Commission*, 76 ALB. L. REV. 757, 759 (2012–2013) ("Not since the flag desecration cases of the late 1980s and early 1990s and the proposed constitutional amendments following them, have we seen anything in the First Amendment area quite as divisive as the Court's 2010 campaign finance ruling.").

115. Citizens United v. Fed. Election Comm'n, 558 U.S. 310, 319 (2010).

116. *Id.* at 466 (Stevens, J., Ginsberg, J., Breyer, J., Sotoymayor, J., dissenting).

the correct limits of a legal fiction, the issue would be easier to settle (or, more cynically, the fiction would be harder to manipulate).

B. Why Brain Death is an Unacknowledged, Status Legal Fiction

The historical development of brain death reveals that it was not based on the discovery of a new form of biological death but rather was a pragmatic solution to several different problems. When Henry Beecher and the Harvard Ad Hoc Committee first proposed the concept of brain death, they did so to resolve two important practical problems for the field of medicine: the waste of resources spent on people who will not recover consciousness and the need to have organs for transplantation.[117] Robert Veatch, a graduate student at Harvard at the time of the Ad Hoc Committee's deliberations, worked closely with several Committee members.[118] He argued that they did not believe that brain death was the equivalent of biological death.[119] As Veatch explained:

> [T]he committee members implicitly held that, even though these people are not dead in the traditional biological sense, they have lost the moral status of members of the human moral community. They believed that people with dead brains should no longer be protected by norms prohibiting homicide.[120]

In a 1968 article, Henry Beecher asked a question that seems to confirm Veatch's view:

> In failing (so far) to accept irretrievable coma as a true indication of death, society condones the discard of the tissues and organs of the hopelessly unconscious patient when they could be used to restore the otherwise hopelessly ill but still salvageable individual. Can society afford such waste?[121]

One scholar has noted that Beecher was concerned about the ethics of human experimentation[122] and that he thought that using

117. Ad Hoc Committee, *supra* note 31, at 677.
118. Robert M. Veatch, *Abandon the Dead Donor Rule or Change the Definition of Death?* 14 KENNEDY INST. ETHICS J. 261, 267 (2004).
119. *Id.*
120. *Id.*
121. Henry K. Beecher, *Ethical Problems Created by the Hopelessly Unconscious Patient*, 278 N. ENG. J. MED. 1425, 1425 (1968).
122. Pernick, *supra* note 59, at 3, 10 (citing Henry K. Beecher, *Ethical Problems Created by the Hopelessly Unconscious Patient*, 278 NEW ENG. J. MED. 1425, 1430 (1968)).

brain-dead individuals as human research subjects might avoid these ethical concerns.[123] This suggests that Beecher's intention in setting up the Harvard Ad Hoc Committee was not to ensure that the law recognized a form of death it had previously neglected but rather to address important practical concerns.[124]

Alex Capron, the future head of the Bioethics Commission that issued the canonical report *Defining Death*, was an early commentator on the legal problems associated with brain death and organ transplantation.[125] Capron addressed the concern that, without statutes recognizing brain death, transplant surgeons were possibly liable for homicide.[126] As a solution, he proposed that the law should recognize that "a patient may be declared dead on the basis of a permanent and irreversible cessation of spontaneous activity in his brain."[127] The practical focus of Capron and other influential figures, who worked to change how physicians determined death, demonstrates that they were concerned about the usefulness of neurological criteria for death and not necessarily about whether these criteria tracked a newly discovered biological truth about the nature of death.

Early doubts about the adequacy of brain death as a concept also existed. In Beecher's correspondence and writings, he expressed uncertainty over whether to think of "hopelessly unconscious" patients as dead.[128] For instance, he argued that "[a]lthough some have attempted to make a case for the concept of a corpse as one who is unconscious and suffering from incurable brain damage, one can nevertheless orient the situation swiftly by a single wry question: 'Would you bury such a man whose heart was beating?'"[129] Yet Beecher also "shifted back and forth between endorsing and rejecting consciousness as the conceptual foundation of his diagnostic criteria,"[130] betraying uncertainty about the basis for determining that brain death was a form of death.

In addition to Beecher's doubts about brain death, prominent scholars presented early critiques of brain death.[131] In 1982, Mark

123. *Id.* at 10.
124. *Id.*
125. *See* Alexander M. Capron, *To Decide What Dead Means*, N.Y. TIMES, Feb. 24, 1974, at 6-D.
126. *Id.*
127. *Id.*
128. Beecher, *supra* note 121.
129. *Id.* at 1426.
130. Pernick, *supra* note 59, at 12.
131. *See* Hans Jonas, *Against the Stream: Comments on the Definition and Redefinition of Death*, in PHILOSOPHICAL ESSAYS 132, 138 (1974) ("We do not know with certainty the borderline between life and death, and a definition cannot substitute for knowledge. Moreover, we have

Siegler and Dan Wikler responded to cases involving pregnant, brain-dead women by stating, "It has been known for some time that brain-dead patients, suitably maintained, can breathe, circulate blood, digest food, filter wastes, maintain body temperature, generate new tissue, and fulfill other functions as well."[132] Siegler and Wikler raised some of the same concerns mentioned in the Muñoz case, discussed *infra*, and concluded that: "The death of the brain seems not to serve as a boundary; it is a tragic, ultimately fatal loss, but not death itself. Bodily death occurs later, when integrated functioning ceases."[133] They also suggested that, though brain death might be an appropriate legal or moral construction, it was not a valid biological or medical one.[134] Both considering brain death the same as biological death and the largely pragmatic reasons for developing the concept suggest that under Fuller's definition, brain death was a legal fiction. It was "propounded with . . . partial consciousness of its falsity"[135] and was justified from the beginning by its utility.

The historical development of brain death suggests that it is a status legal fiction, which relies upon an analogy between brain death and the traditional view of death. The analogy is as follows: like cardiopulmonary death, brain death does considerable damage to the brain and causes an irreversible loss of consciousness. Someone who is brain dead, like a corpse, has lost consciousness and the ability to interact in any meaningful way with others and the outside world.

However, this analogy is limited. Unlike people who are dead according to cardiopulmonary criteria, brain-dead patients' bodies do not grow cold, retain the ability to heal wounds, and can, in some cases, gestate babies successfully.[136] Thus, the best way to understand brain death is as a status legal fiction. It is therefore appropriate to treat brain death as death in some respects, while also recognizing its limits.

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sufficient grounds for suspecting that the artificially supported condition of the comatose patient may still be one of life, however reduced—i.e., for doubting that, even with the brain function gone, he is completely dead. In this state of marginal ignorance and doubt the only course to take is to lean over backward toward the side of possible life."). Jonas also raises concerns that the desire for organs for transplantation motivated the Ad Hoc Committee's redefinition of death and that the same logic would permit using brain dead individuals as organ banks, blood banks, and subjects in troubling experiments. *Id.* at 133, 137.

132. Mark Siegler & Daniel Wikler, *Brain Death and Live Birth*, 248 J. AM. MED. ASS'N 1101, 1101 (1982).

133. *Id.*

134. *Id.* at 1102.

135. FULLER, *supra* note 17, at 9.

136. PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 40.

An alternative view is that brain death is not a fiction but a way of legally adopting a personhood view of death. The idea is that once consciousness and higher brain function are permanently lost, the person is gone and death has occurred. Bob Veatch's recollection of his interactions with the Ad Hoc Committee suggests this view,[137] and some scholars have argued for a personhood view of death.[138] One problem is that there is no clear indication that this is what motivated the adoption of brain death initially. In fact, both the President's Council and President's Commission expressly rejected a personhood standard of death.[139] Additionally, people who are in a persistent vegetative state seem to have permanently lost consciousness but are clearly not brain dead.[140] The legal and medical fields do not currently treat people with those disorders of consciousness as dead.

Additionally, no jurisdiction uses a personhood standard of death,[141] and a shift to that standard would necessitate dramatic legal change. What counts as a person is already hotly contested. Given the controversy surrounding definitions of personhood, it is hard to imagine that a democratic process would adopt a personhood standard of death. Thus, a personhood standard of death is not the correct way to characterize the legal standard of brain death and is unlikely to provide much legal utility.

Different kinds of legal fictions exist. Several authors have acknowledged that brain death may be a legal fiction but have contended that it is a bright-line fiction or a fiction that draws a sharp line between two states when there is not a clear boundary between them.[142] For instance, Alta Charo has argued that defining death requires bright-line fictions because of the difficulty involved in determining precisely when death occurs.[143] Others argue that brain death is an "important social construction."[144] They further contend that, given that dying is a process, "the decision reached by the medical and particularly the neurology community to articulate

137. *See* Veatch, *supra* note 118, at 267–68.

138. *See, e.g.*, *id.* at 268–69; John P. Lizza, *Defining Death for Persons and Human Organisms*, 20 THEORETICAL MED. & BIOETHICS 439, 439 (1999).

139. PRESIDENT'S COMMISSION, *supra* note 25, at 40–41; PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 50–52.

140. *See* Stephen Holland, et al., *Death, Treatment Decisions, and the Permanent Vegetative State: Evidence from Families and Experts*, MED. HEALTH CARE & PHIL., 413, 414 n. 5 (2014).

141. PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29.

142. Shah & Miller, *supra* note 83, at 560.

143. Alta R. Charo, *Dusk, Dawn, and Defining Death: Legal Classifications and Biological Categories*, *in* THE DEFINITION OF DEATH: CONTEMPORARY CONTROVERSIES 277, 277 (Stuart Youngner et al. eds., 1999).

144. David C. Magnus, Benjamin S. Wilfond & Arthur L. Caplan. *Accepting Brain Death*, NEW ENG. J. MED. 891, 893 (2014).

and promulgate the concept of brain death as the right place to draw the line between life and death is extremely reasonable."[145]

However, a bright-line fiction does not accurately describe the legal fiction of brain death. In a standard bright-line fiction, the law uses a bright line to demarcate a boundary that does not really exist to make it easier for judges or other legal actors to administer and apply the fiction.[146] The legal rule will be both over- and under-inclusive. For instance, in many jurisdictions eighteen is the age when individuals are considered adults who are capable of consent. This bright line neglects the fact that some children under the age of eighteen are already mature and that some adults over the age of eighteen never quite reach maturity. Bright lines make rules that are easy to apply but that may reach undesirable or incorrect results in certain cases.

Even if bright lines create boundaries where none really exist, they are valuable and necessary in many cases and are likely to be wrong mainly at the margins. Some amount of error may make it easier and less costly to administer rules. Courts should not adopt bright-line fictions if the bright lines do not, by and large, obtain the right results. For instance, imagine if there were scientific evidence that ninety-nine percent of all eighteen- and nineteen-year-olds lack the capacity to make decisions because a crucial developmental step does not occur until the age of twenty. In that case, courts should reconsider the rule. Similarly, a rule that only thirty-five-year olds had full decision-making autonomy would get the result wrong too often to count as a reasonable bright line.

By contrast, a classic legal fiction is understood as false most of the time without undermining the reasons for initially adopting the fiction. A strict bright-line rule concerning neurological death is unproductive as two states have exceptions to accommodate religious views that do not accept brain death.[147] Moreover, the evidence shows that many people who are accurately diagnosed as brain dead retain some brain function and various types of integrative functioning.[148] This suggests that the fiction of brain death is simply false much of the time, not just at the margins.

Status legal fictions are usually transparent. For instance, corporations are not human beings, and no one would mistake civil death

145. *Id.* at 893.
146. Shah & Miller, *supra* note 83, at 561.
147. Robert S. Olick, Eli A. Braun & Joel Potash, *Accommodating Religious and Moral Objections to Neurological Death*, 20 J. CLINICAL ETHICS 183, 183 (2009) (discussing how New York and New Jersey reasonably accommodate a patient's religious or moral objection to determining death on the basis of neurological criteria).
148. *See, e.g.*, *supra* Part I.C.

for biological death. Yet, brain death is only partially transparent. It is also a confusing subject for the public when physicians and scholars routinely argue that brain death is the same as death. Thus, whole brain death is an especially dangerous type of legal fiction since it is opaque, unacknowledged, and therefore vulnerable to misuse.[149] Given the dangers associated with using this legal fiction, an important question to ask is whether it does more harm than good. If this legal fiction is not ethically justifiable on balance, the law should eliminate it.

C. Is the Legal Fiction of Brain Death Justifiable?

Even given the costs of developing unwieldy or partially dishonest extensions of the law, scholars have argued that legal fictions are permissible.[150] The legal fiction of brain death exists to respond to practical problems generated by the introduction of new life-sustaining technologies.[151] These technologies have likely saved many lives and have made it possible to maintain patients beyond the point of recovering consciousness or interacting meaningfully with the world.

Providing legal recognition of brain death as death had several benefits. First, hospitals and families became empowered to withdraw treatment from brain-dead patients.[152] This permitted families to fully grieve and move on. It allowed families to honor the wishes of patients, who did not want to be maintained on life support indefinitely with no chance of returning to a relatively well-functioning life. Hospitals could also distribute scarce resources in intensive care units to patients who had a chance to restore significant function. Legal recognition of brain death, therefore, prevented the continued use of limited resources for people who would never have a meaningful recovery.

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149. *See* Shah & Miller, *supra* note 83.

150. Blackstone contended that a fiction could be worthwhile as long as it does not "extend to work an injury; it's [sic] proper operation being to prevent a mischief." BLACKSTONE, *supra* note 91.

151. *See* Ad Hoc Committee, *supra* note 31, at 677–79.

152. *See* M. Smith, *Brain Death*, 108 BR. J. ANAESTH i6, i6 (2012) (explaining that "the confirmation of brain death allows the withdrawal of therapies that can no longer conceivably benefit an individual who has died."). Of course, once the Supreme Court recognized the right to refuse consent to life-sustaining therapy, the legal fiction of brain death was no longer strictly necessary for individuals or families to decide to withdraw care, but it is still necessary to allow hospitals to make the decision to withdraw brain-dead patients from life-sustaining therapy when a family objects. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 270 (1990).

Second, treating brain death as biological death contributed significantly to organ transplantation.[153] Brain-dead donors are ideal sources of organs. Their organs continue to receive blood flow and oxygen from hearts that still beat, unlike the organs donated from cadavers. Thus, patients who meet neurological criteria for death are "the preferred source of organs" compared to individuals determined dead based on cardiopulmonary criteria. [154]

Yet the "dead donor rule"—the still-existing ethical and legal constraint that holds that doctors cannot remove vital organs necessary to keep bodies alive from patients until they are dead—stood in the way.[155] The view that opposes procuring vital organs until the donor is dead is widely held. Surgeons who transplant organs from patients are possibly culpable of homicide unless their patients were legally dead before the operation.[156] Gary Greenberg noted "[b]y the nineteen-sixties, as doctors began to perfect techniques for transplanting livers and hearts, the medical establishment faced a paradox: the need for both a living body and a dead donor."[157] There is a tremendous need for organ transplantation even today, and over 120,000 people are currently on waiting lists for organ donation.[158] Treating brain death as legal death made it possible to save many lives through organ transplantation without physicians having to violate the dead donor rule and suffer drastic legal consequences.

Is saving lives through organ transplantation sufficient to justify using brain death as a legal fiction? Is the justification for the legal fiction a purely utilitarian argument that neglects important ethical constraints? The dead donor constraint is both a legal and ethical constraint. Frank Miller and Bob Truog have argued that the current practice of organ donation, premised on using brain death as a legal fiction, is ethically justifiable.[159] A patient must be in a state of irreversible coma to be declared dead under neurological criteria,

153. *See* Shah & Miller, *supra* note 83, at 569.

154. PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 8.

155. MILLER & TRUOG, *supra* note 4 at 113. The dead donor rule is not an express legal prohibition but a long-standing and cross-cutting prohibition that is found in many places. As such, determining the limits of the dead donor rule are difficult, especially in order to determine whether it contemplates the use of a legal fiction to determine death. As this Article argues below, however, there is good reason to extend the legal fiction of brain death to apply to the dead donor rule.

156. John Robertson, *Should We Scrap the Dead Donor Rule?*, 14 AM. J. BIOETHICS 52, 52 (2014).

157. Gary Greenberg, *As Good as Dead*, THE NEW YORKER, Aug. 13, 2001.

158. *Data Reports*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, http://optn.transplant.hrsa.gov/data/ (last visited Feb. 10, 2014).

159. Franklin G. Miller & Robert D. Truog, *Rethinking the Ethics of Vital Organ Donations*, 38 HASTINGS CTR. REPORT 38, 39–40 (2008).

which is characterized by the permanent loss of consciousness.[160] Although brain-dead patients can do many things that seem consistent with life and may persist for years on ventilators after being determined brain dead, they have permanently lost the ability to connect or interact with others in a meaningful way. Brain-dead patients cannot communicate with their loved ones, leave their hospital beds under their own volition, express desires or wishes, make decisions, or interact with others in any meaningful way. Though there are many published reports of brain-dead patients persisting on ventilators for many years, healing wounds, maintain warm body temperatures, and gestating babies, no single case exists of a brain-dead patient recovering consciousness or the ability to interact with others.[161]

Miller and Truog, therefore, argue that brain-dead patients can be considered "as good as dead" for the purpose of deciding when to withdraw life-sustaining therapy and permit the procurement of organs. Because brain-dead patients have permanently lost consciousness and their ability to interact with the world in a meaningful way, as long as they or their surrogates give informed consent to withdraw therapy and donate their organs, they have not been harmed or wronged.[162] After a determination of brain death, it is therefore ethically justifiable to allow patients to decide prospectively to serve as organ donors (through an organ donor card or an advance directive) or to allow their families to permit the procurement of organs from brain-dead patients. Miller and Truog also find it justifiable for hospitals to stop providing therapy for

160. *Id.* at 39.

161. For an overview of the evidence on outcomes related to brain dead patients and the preservation of integrative functioning, see PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 29, at 40. Of course, the development of future technology could possibly change this. *See, e.g.*, Norimitsu Onishi, *A Brain Is Dead, a Heart Beats On*, N.Y. TIMES, Jan. 3, 2014, at A10. Some would also argue that society may simply lack the evidence to know for certain whether some brain dead patients can recover, given that brain dead individuals typically are not maintained on life support for long periods of time since it is difficult to defend the extensive use of resources required to do so. *See* Ronald Cranford, *Even the Dead Are Not Terminally Ill Anymore*, 51 NEUROLOGY 6, 1531 (1998) ("It is impossible to know with certainty the extent of prolonged survival in brain death because a systematic clinical study in which the cardiac and circulatory functions are sustained for prolonged periods (weeks, months, or years) in a large number of patients is morally indefensible, extraordinarily expensive in terms of money and resources of manpower and intensive care unit beds, and legally prohibitive.").

162. Miller & Truog, *supra* note 155, at 145–46. *But see* Nair-Collins, *supra* note 2, at 56 ("By contrast, theorists such as Paul Byrne, Michael Potts, and several others are in agreement with Miller and Truog that brain death is not death and organ removal kills the donor. However, these authors . . . accept the dead donor rule, and thus object to the removal of nonpaired vital organs from brain death patients, since such patients are, on this view, alive.").

brain-dead patients though they leave open the possibility that hospitals should reasonably accommodate the views of individuals who do not accept brain death.[163]

The legal fiction of brain death has previously under-recognized costs. The *McMath* and *Muñoz* cases discussed above demonstrate that treating brain death as legal death can lead to confusing and undesirable outcomes in a number of legal scenarios in which a brain death standard is not appropriate. The next Part explores whether creating limits on the legal fiction of brain death can manage these costs.

III. WHEN TO SUSPEND THE LEGAL FICTION OF BRAIN DEATH

Even with the significant benefits this legal fiction offers, cases illustrate times when the legal fiction of brain death is unhelpful or counterproductive. Just as "piercing the corporate veil" occasionally suspends the legal fiction of corporate personhood,[164] hospitals and doctors should sometimes decline to use the legal fiction of brain death and treat brain-dead individuals as alive instead.

One potential objection to this line of argument is that suspending the legal fiction of brain death in some, but not all, instances might lead to more confusion and might undermine the fiction's utility. If legal fictions extend the law quickly and seamlessly into a new domain, then recognizing limits to a legal fiction will undermine that goal. Therefore, if limits to a legal fiction are needed, perhaps the law should abandon the fiction and transparently decide issues on a case-by-case basis.

This objection has some merit, and the legal fiction of brain death is clearly not ideal. Maintaining this legal "scaffolding" has some costs. Yet, since charges of death panels garner public attention and concern,[165] states will likely keep the dead donor rule. In

163. *See* Miller & Truog, *supra* note 155, at 45. Michael Nair-Collins recently raised an important caveat to this view while looking at the evidence about how consent for organ donation is obtained. He found several examples of inaccurate, if not deceptive, information about brain death given to individuals prior to asking for their consent. He rightly questions the validity of the consent currently obtained from individuals or family members, if this consent is given in reliance on misleading information. If brain death was transformed into a transparent, acknowledged legal fiction, hospitals would need to change the current practices of obtaining informed consent for organ transplantation and withdrawal of therapy from brain dead patients. *Id.* at 81–87.

164. Thompson, *supra* note 18, at 3, 9.

165. *E.g.*, Ben Cosman, *Death Panels Will Be Sarah Palin's Greatest Legacy*, THE WIRE (May 30, 2014), http://www.thewire.com/politics/2014/05/death-panels-will-be-sarah-palins-greatest-legacy/371888/ (discussing the continued media prominence of the phrase "death panels," which was coined by Sarah Palin in reference to aspects of the Affordable Care Act).

this context, the legal fiction of brain death should become more transparent to ensure that it is accurately applied.

In some respects, recognizing limits to the legal fiction of brain death is nothing new. Doctors already treat brain-dead individuals differently than biologically-dead people. For instance, brain-dead patients are not immediately disconnected from ventilators to dispose of their remains. Physicians typically give families time to say goodbye and have qualms about burying a body still warm to the touch. The U.S. military has kept brain-dead service members on ventilators in order to give family members time to say goodbye.[166] In one published case, a hospital accommodated the wishes of family members, who wanted to keep a brain-dead patient on a ventilator to try an alternative medicine remedy.[167] Cases like these demonstrate that the practice of suspending the legal fiction of brain death in some cases is fairly well-accepted, even if it is not fully recognized. Regardless, the commentary on the *McMath* and *Muñoz* cases does not fully acknowledge that brain death is a legal fiction[168] and therefore exposes the public to confusing and potentially misleading interpretations of these cases.

In sum, the *McMath* and *Muñoz* cases illustrate why it is important to avoid using the legal fiction of brain death with respect to: (1) legal accommodations for religious and moral objections to brain death, (2) insurance reimbursement for care of brain-dead patients, and (3) the balancing of constitutional rights and interests of pregnant women who are brain dead. This Part will also briefly touch on other situations in which doctors should recognize brain-dead individuals as alive and should treat accordingly.

A. The McMath *Case: Religious and Moral Objections to Brain Death*

In the *McMath* case, Jahi McMath became brain dead after complications from a surgical procedure.[169] Given that the family did not expect this outcome, they may have lost trust in the physicians

166. *See* Gregg Zoroya, *U.S. Troops' Organ Donations Save European Lives*, U.S.A. TODAY, http://www.usatoday.com/news/military/story/2012-05-03/militaryorgandonations/54733132/1 (May 4, 2012).

167. Arthur Isak Applbaum et al., *A Family's Request for Complementary Medicine After Patient Brain Death*, 299 J. AM. MED. ASS'N 2188 (2008). In this case, the physicians kept the patient on the ventilator for a few days to accommodate the family and allow for another family member to arrive.

168. *See, e.g.*, Gostin, *supra* note 20; Magnus et al., *supra* note 144.

169. Lisa Fernandez, *Judge Orders Hospital to Keep Jahi McMath on Life Support*, NBC BAY AREA, http://www.nbcbayarea.com/news/local/Judge-Orders-Oakland-Hospital-to-Keep-Jahi-McMath-on-Life-Support-236808851.html.

and hospital staff and found it difficult to believe the doctors concerning brain death. The family may also have distrusted the physicians because they did not acknowledge that brain death is a legal fiction. Members of the lay public may find brain death hard to understand when they are told that their family members are dead but can see their loved one breathe, maintain warmth, and grow a beard, regardless of his dependence on a ventilator.[170] Having a physician state unequivocally that someone who is brain dead is dead, despite displaying visible signs associated with life, is incredibly hard to believe. For those who already lack trust in their physicians, the claims are possibly even harder to believe. In the *McMath* case, the family did not appear to believe that Jahi McMath had permanently lost her ability to interact with the world in a meaningful way.[171]

The McMath family might have had reasons to seek continued care for Jahi. First, if the family had strong views that all life is sacred and was willing to pay or obtain financing for Jahi's care to keep her alive, their deeply held beliefs might have motivated their decision. For example, some segments of Orthodox Judaism and Japanese society reject a neurological determination of death, and there have been reports of some Roman Catholic and Islamic religious leaders also rejecting brain death.[172]

Accommodating these views is important. First, robust democratic deliberations did not decide to treat brain-dead patients as biologically dead. As discussed in Subsection II.B, hospitals adopted neurological criteria for death based on the urging of the Harvard Ad Hoc Committee and the blessing of the President's Commission. Neither organization transparently acknowledged doubts about brain death that existed at the time. If making sense of brain death relies on the idea that after certain brain functions permanently cease the person is gone forever, then this view is not strictly biological. It requires a broader sense of what a person is, which is a

170. G. Marmisa and J.L. Escalante, *Organ Donation Interviews in Community of Madrid, Spain*, 34 TRANSPLANT. PROC. 23 (2002) (twelve out of 758 families refused to donate organs based on disbelief in the concept of brain death)*; see also* Maryse Pelletier, *The Organ Donor Family Members' Perception of Stressful Situations During the Organ Donation Experience*, 17 J. ADV. NURS. 90, 93 (1992) (in a small qualitative study of seven family members of deceased patients, found that two participants found brain death difficult to reconcile with death when their family members' bodies were still warm and perspiring, and their beards were still growing, and one participant stated that her husband's "heart was pumping away when he was pronounced dead. He appeared alive yet he [the physician] had just told me he was dead. How could I believe he was dead?").

171. Fernandez, *supra* note 169 (quoting Jahi McMath's mother's written plea to the court: "She is alive. I believe in God and that He can heal all. God created Jahi. He can save her.").

172. Olick, *supra* note 147, at 186.

contested notion for which there is no universal consensus. Religious accommodations have an important place in many different legal domains.[173] Given the relatively shaky democratic foundations of the legal fiction of brain death, accommodating opposing views about death seems especially warranted.

Second, biology suggests that brain death is not a valid conception of death. The evidence about brain death suggests that although it may be "as good as dead" for some purposes, significant differences exist between brain death and a traditional, biological conception of death. If patients and families have very deeply held religious or moral views about the sanctity of life, it is reasonable for them to reject equating brain death and biological death. By contrast, consider a case involving people with religious beliefs that rejected a cardiopulmonary definition of death and believed, even after a body turns cold and stiff and begins to decay, religious intervention could bring a person back to life. There is little reason to accommodate religious or moral views that lack any biological plausibility. Furthermore, practical reasons support the medical profession or the law declining to accommodate such views. Hospitals should not keep corpses, which are taking the place of other patients, for days. The law's concerns about the orderly distribution of assets and timely administration of criminal sanctions against people who have committed homicide support a sunset period.

The treating physicians and the hospital administration in the *McMath* case had to weigh the family's claims for respect and accommodation against need to efficiently allocate scarce resources. Although the law should not force hospitals to provide the same care for patients who are not likely to meaningfully recover as care for patients with a better chance at recovery, they should acknowledge and respect patients and family members' deeply held views, and facilitate transferring patients to capable facilities.

Currently, only two states require hospitals to accommodate patients and family members who have strong religious views about the sanctity of life that would impel them not to take brain-dead patients off ventilators.[174] Particularly given that brain death is not the same as a traditional, biological death, the law should respect

173. *See, e.g.*, Title VII of the Civil Rights Act, 42 U.S.C. § 2000e(j) (1964) (defining "religion" as aspects of religious belief that an employer can reasonably accommodate in the workplace); Timothy J. Aspinwall, *Religious Exemption to Childhood Immunization Statutes: Reaching for a More Optimal Balance between Religious Freedom and Public Health*, 29 LOY. U. CHI. L.J. 109, 109 (1997-1998) (noting that forty-eight states have religious exemptions to the requirement to receive certain vaccinations before enrollment in public schools).

174. Olick et al., *supra* note 147, at 183.

these deeply held beliefs. Additionally, the two states that allow exceptions to the neurological determination of death have not had significant trouble administering their laws.[175] Thus, an important legal reform is for all states to require reasonable accommodation of religious and moral beliefs that brain death is not death.

One published case of accommodation raised questions about how long to provide care, who pays for that care, and whether health professionals could conscientiously object to participating in the continued care of a brain-dead patient.[176] Hospitals have to balance scarce resources and other patients' needs against any accommodation for brain-dead patients, especially since end of life care is very costly.[177] Hospitals can place some limits on the care they provide to accommodate families through providing care for brain-dead patients for days at a time, caring for brain-dead patients outside the Intensive Care Unit (ICU), minimizing the interventions used to those that are necessary to ensure cardiac function continues, and reserving the right to withdraw all interventions if other patients are in greater need.[178] Some reasonable limits on treatment make sense to give the family time to see if a transfer to a different facility is possible and in the period before such a transfer. Considerable disagreement may surround the proper limits of care, but everyone can likely agree on one example. Consider the somewhat far-fetched case of a family requesting that a brain-dead patient be placed on a waiting list to receive a donated organ. It is hard to imagine that anyone would think that equal consideration be given to the brain-dead patient as a person who is conscious, able to breathe on his or her own, and who can interact with others in meaningful ways.

Only New Jersey requires that insurance companies pay for care provided to brain-dead patients during the time of accommodation.[179] In one case, the patient was not immediately declared brain dead because the spouse initially did not want the doctors to perform neurological tests in order to have the insurance company pay for the care as it would for any other patient.[180] Likely, the delay in determining brain death led to increased costs of care.[181] Hospitals

175. *Id.* Note that California also has a statute that requires "a reasonably brief period of accommodation." *See* Thaddeus Mason Pope, *Legal Briefing: Brain Death and Total Brain Failure*, J. CLINICAL ETHICS 245, 247–48 (2014).
176. Olick et al., *supra* note 147, at 189.
177. *See* Paul E. Marik, *The Cost of Inappropriate Care at the End of Life*, AM. J. HOSP. PALLIAT. CARE 2 (2014).
178. Olick et al., *supra* note 147, at 188.
179. *Id.* at 198.
180. *Id.* at 189.
181. *Id.*

can pay for some of the care out of their charity budgets.[182] Many other worthy uses of a hospital's charity funds exist, including providing care for people who are likely to recovery and cannot afford to pay. A policy that requires funding the care of brain dead patients also has the potential to exhaust the hospital's charity funds. Should health insurance cover the care provided to accommodate religious and moral objections to brain death? This accommodation is possibly very expensive care. When brain-dead patients are maintained on ventilators for organ procurement, the organ procurement agency pays for the care since the care is for the benefit of the organ recipient.[183] Thus, it may make sense to have the accommodated individual pay for the care. Individuals should be able to purchase insurance that will cover this possibility. This would allow people to buy policies or additions to policies to accommodate their deeply held views and provide reimbursement for care provided to brain-dead patients.[184]

B. The Muñoz *Case: Constitutional Rights of Brain-Dead Patients*

The *Muñoz* case raises a more complex set of issues. The court deciding the case applied the statutory definition of death to determine that the statute requiring keeping pregnant patients on life support did not apply to Ms. Muñoz.[185] This turned out appropriately but slightly different facts could have led to disturbing results. Deciding whether to continue life-sustaining therapy for a pregnant, brain-dead woman is one area to suspend the legal fiction of brain death because failing to do so obscures that important constitutional rights and fundamental interests are at stake.

Scholars and legal actors involved in creating the legal fiction of brain death did not anticipate that cases involving pregnant, brain-dead women were likely to arise. The legal fiction was created to

182. *Id.*

183. *Id.*

184. The existence of organizations such as the Terri Schiavo Foundation (www.terrisfight.org) suggests that sufficient demand may exist for an insurance market to provide care for brain dead patients.

185. Muñoz v. John Peter Smith Hospital, No. 096-270080-14, Judgment (96th Dist. Jan. 24, 2014) (holding that: "1. The provisions of § 166.049 of the Texas HEALTH AND SAFETY CODE do not apply to Marise Muñoz because, applying the standards used in determining death set forth in § 671.011 of the Texas HEALTH AND SAFETY CODE, Mrs. Muñoz is dead. 2. In light of that ruling, the Court makes no rulings on the Plaintiff's constitutional challenges to § 166.049.").

save lives through organ donation and to ease the burdens on hospitals and families.[186] By contrast, when a pregnant woman becomes brain dead, the question of maintaining her on life support has a direct impact upon the fetus she is gestating.

Muñoz is also important because this situation may recur. Texas lawmakers are considering modifying the law to address future cases, but lawmakers on different sides of the aisle have contrasting inclinations about the statute's application to pregnant women.[187] Prior to 2009, twenty-two published reports of maintaining pregnant brain-dead women to save their fetuses were found, and all but two of these resulted in the fetus being born alive.[188] Another case has since arisen in Canada, but in that case the brain-dead woman's physicians and partner agreed to continue treatment.[189] The child was born after twenty-eight weeks gestation and appears healthy.[190]

Previous cases of pregnant women becoming brain dead have sparked controversy, with some commentators expressing strong views about the need to preserve the life of the fetus at all costs[191] and others raising concerns about the pregnant woman's dignity.[192] Additionally, one scholar argued that in jurisdictions that accept brain death, a brain-dead pregnant woman "could be viewed as a newly deceased, still-respiring cadaver being used as an incubator for her fetus."[193] Veatch contends under those circumstances, the "relevant legal and ethical literature is now clear that the use of a newly dead, respiring cadaver should be governed by the provisions

186. *See* Ad Hoc Committee, *supra* note 31, at 677.

187. *See* Lauren Zakalik, *Muñoz case could bring changes to Texas Health Code*, WFAA.COM (Jan. 27, 2014), http://www.wfaa.com/news/health/Muñoz-case-spurs-legislative-interest-in-end-of-life-cases-242305371.html.

188. Anita J. Catlin & Deborah Volat, *When the Fetus Is Alive but the Mother Is Not*, 21 CRIT. CARE NURS. CLIN. N. AM. 267, 268 (2009). The authors found that some fetuses had been maintained from as early as fifteen weeks' gestation. Additionally, one pregnant woman stayed on life support for as long as 107 days. *See id.* at 269.

189. *Braindead woman gives birth to healthy baby then passes away*, MAIL ONLINE, http://www.dailymail.co.uk/news/article-2556485/Braindead-woman-Robyn-Benson-gives-birth-healthy-baby-taken-life-support-day.html (last visited Oct. 8, 2014).

190. *Id.*

191. *See, e.g.*, Christoph Anstötz, *Should a Brain-Dead Pregnant Woman Carry Her Child to Full Term?*, 7 BIOETHICS 340, 341–42 (1993) (quoting the assistant medical director at the university hospital as saying "on the grounds of proportionality . . . it is probably reasonable to impose on the mother, through the use of her body, for the benefit of the child . . . " and "we don't see any ethical reason simply to let the embryo die.").

192. *See, e.g.*, *id.* at 344 (quoting Hanna Wolf, a governmental spokeswoman for Women's Affairs, as saying the following: "What is happening in the clinic is a scandal and inhuman. The mother is degraded to a nutrient fluid, disposable after use" and raising concerns about whether keeping the pregnant woman on the ventilator violated the provision of the German constitution protecting human dignity).

193. Robert Veatch, *Maternal Brain Death: An Ethicist's Thoughts*, 248 JAMA 1102, 1103 (2004).

of the Uniform Anatomical Gift Act (UAGA)."[194] He states that to use this woman's body to support her fetus, the UAGA would require either that the woman had prospectively consented to be an organ donor or that her next of kin give proxy consent to use her organs.[195] This is the kind of convoluted reasoning the legal fiction of brain death requires, and it seems unhelpful for resolving cases like these. Simply in terms of who will be affected by the decision, consent to organ donation is very different from consent to continue to treat a pregnant, brain-dead body. It is also unclear how to apply the UAGA to cases involving brain-dead, pregnant woman—is the fetus the "gift", the recipient of the donation, or both?[196] The intent behind organ donation is also very different than a pregnant woman's decision about her fetus. A pregnant, brain-dead woman might have wanted to save others' lives as an organ donor but not to continue a particular pregnancy after brain death. On the other hand, some women may have qualms about organ donation but would want to save their fetus at any cost.

Some courts have suggested that pregnant, brain-dead women may have diminished or extinguished constitutional rights. In one case, the hospital withdrew treatment once court-appointed physicians determined that a pregnant woman was brain dead, even over her common-law husband's objections, without trying to determine her prior wishes.[197] Another case involved a brain-dead pregnant woman on a ventilator, who was at twenty weeks gestation when her husband sought to have her taken off the ventilator.[198] Her husband was not her child's father, however, and the biological father sought an order to maintain her on life support.[199] The woman's prior wishes were not discussed, and the court might not have known them.[200] That case held that the woman should be maintained on life support but also that the mother's right of privacy was extinguished when she was declared brain dead.[201]

In analyzing cases involving pregnant, brain-dead women, the first question that arises is whether the rights of brain-dead individuals are extinguished when they are determined brain dead. This

194. *Id.*
195. *Id.*
196. *See* Daniel Sperling, *Maternal Brain Death*, 30 AM. J.L. & MED. 453, 470 (2004).
197. *See, e.g.*, *Docs say mom, fetus dead; Finding ends fight over life support*, SAN ANTONIO EXPRESS-NEWS, Aug. 14, 1999, at 8B. In that case, a neonatologist found no evidence of a fetal heartbeat.
198. Univ. Health Servs., Inc. v. Piazzi, Hadden, & Div. Fam. & Child. Serv., No. CV86-RCCV-464, slip. op. at 1–2 (Ga. Super. Ct. of Richmond Cnty. Aug. 4, 1986).
199. *Id.* at 3.
200. *See id.* at 2–3.
201. *Id.* at 4–6.

conclusion seems flawed because courts have recognized that even people who are biologically dead have constitutional rights worthy of legal protection.[202] Kirsten Smolensky noted that courts have recognized that celebrities' right of publicity can survive their deaths[203] and have protected the right to reproductive autonomy after death in cases involving the use of frozen sperm or embryos.[204] The Supreme Court has recognized that attorney-client privilege extends after death.[205] Since both living and dead persons' constitutional rights are legally protected, whether someone is brain dead should not determine whether his or her constitutional rights deserve respect. However, given that brain-dead people will never regain consciousness, sufficient ethical justification may support a legal recognition that their interests have diminished value if they will not thereby be harmed or wronged.[206]

Smolensky addressed maternal brain death cases, briefly noting that some states will invalidate an advance directive that expresses a woman's preference to terminate life support after brain death. Smolensky suggested two possible reasons: either the harm of remaining on mechanical ventilation after death is diminished if one is already dead, or states simply do not like that the fetus may die along with the woman.[207] This second possibility is problematic, particularly if it impinges on a woman's valid constitutional rights. But it is less clear how to determine the degree of harm done by violating brain-dead patients' autonomous wishes and fundamental rights.

Muñoz raises one of the most fundamental rights at stake in cases of brain-dead pregnant women—the right to withdraw therapy. The Supreme Court recognized a fundamental right to withdraw life-sustaining therapy in *Cruzan* case in 1990, stating that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."[208] The Court decided that states can require a heightened evidentiary standard for withdrawal of therapy because of the decision's irreversible nature, the potential for abuse by family

202. Kirsten Rabe Smolensky, *Rights of the Dead*, 37 HOFSTRA LAW REV. 763, 771–72 (2008).

203. *See id.* at 771.

204. *See id.* at 784–86.

205. Swidler & Berlin v. United States, 524 U.S. 399, 410 (1998).

206. Miller & Truog, *supra* note 155, at 41.

207. *See* Smolensky, *supra* note 202, at 786–88.

208. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 270 (1990).

members, and the state's interest in preserving life.[209] *Cruzan* found that the state's interest in preserving life even applied to patients who had very little quality of life, as Nancy Cruzan was in a persistent vegetative state and likely had permanently lost consciousness and significant cognitive function.[210] Although courts have not directly addressed the issue, *Cruzan* suggests that the state still has an interest in preserving the lives of brain-dead patients. Applying *Cruzan* to cases involving pregnant, brain-dead woman complicates the issue since the state has an additional interest in preserving the life of the fetus.[211]

Primarily, cases addressing the right to have an abortion have discussed the balance between a woman's autonomy and the state's interest in preserving the life of a fetus. In *Roe v. Wade*, the Supreme Court recognized that women have a right to have an abortion before the fetus is viable; however, after viability, the state can restrict abortions with certain exceptions permitting abortion to save the life or health of the mother.[212]

The subsequent case of *Planned Parenthood v. Casey* challenged *Roe v. Wade*.[213] Recognizing the importance of *stare decisis*, the Supreme Court upheld that the state's interest in the fetus exists "from the outset" of pregnancy, but changed the focus from the trimester of pregnancy to the question of fetal viability.[214] *Casey* permitted the government to place restrictions on abortions before viability, provided that those restrictions do not unduly burden the woman's right to have an abortion, and allowed more restrictions post-viability.[215] When a fetus is viable depends on the available technology, and fetuses are viable at earlier gestational ages now than at the time of *Roe* and *Casey*.[216] Taken together, *Cruzan*, *Roe*, and *Casey* suggest that, in cases involving a brain-dead pregnant

209. *Id.* at 282 (holding that "we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.").

210. *Id.* at 266.

211. *See, e.g.*, Planned Parenthood v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973).

212. *See Roe*, 410 U.S. at 163–64; *see also* Linda J. Wharton and Kathryn Kolbert, *Preserving Roe v. Wade . . . When You Win Only Half the Loaf*, 24 STANF. L. & POL'Y REV. 143, 151 (2013). Viability of a fetus "means having reached such a stage of development as to be capable of living, under normal conditions, outside the uterus." As of 2012, one article reported that fetuses in the U.S. are typically viable after twenty-four weeks. G.H. Breborowicz, *Limits of fetal viability and its enhancement*, 5 EARLY PREGNANCY 49, 49 (2001).

213. *Casey*, 505 U.S. at 833.

214. *Id.* at 846.

215. *See* Wharton & Kolbert, *supra* note 212, at 151.

216. *See* Breborowicz, *supra* note 212, at 49.

woman, courts should balance the woman's autonomy interests against the state's interest in preserving her life and the life of her fetus. Some commentators have argued that this would cause the following schema: (1) pre-viability, a brain-dead pregnant woman's views should be respected, and (2) post-viability, the state's interest in preserving the life of the fetus should trump any interest a brain-dead pregnant woman might have had in terminating treatment.[217]

Surprisingly, however, the legal distinction between killing and letting someone die may make the abortion jurisprudence inapplicable in cases that involve removing pregnant women from ventilators. Although a strong ethical reason justifies rejecting this distinction,[218] courts have relied upon it to recognize a fundamental right to withdraw therapy but to deny a fundamental right to physician-assisted suicide or euthanasia.[219] In *Vacco v. Quill*, the Supreme Court held that a rational reason supported states' decisions to regulate the withdrawal of therapy and physician assisted suicide differently. The Court held that "when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."[220] The Court also argued that these two situations were critically different—a physician who withdraws therapy intends to respect the patient's wishes and stops providing unnecessary treatment, but a physician who assists a patient in committing suicide (or who euthanizes a patient) has the primary intent of ending the patient's life.[221] Thus, withdrawing therapy from a pregnant, brain-dead patient merely results in the death of the fetus, but was not intended to do so and is not the direct cause of the death. This suggests that abortion case law would not apply to cases of withdrawing therapy from a brain-dead pregnant woman, and that the only fundamental constitutional right at stake is the woman's right to refuse therapy. Nevertheless, the fact that there are strong ethical arguments against maintaining this legal distinction may place decision-makers in a bind. In particular, judges who are inclined to apply the abortion case law may struggle to reconcile their ethical and legal duties.

Courts have balanced the right to refuse therapy against the state's interest in preserving the life of a fetus in cases involving pregnant women who are Jehovah's witnesses and refuse to consent

217. Alexis Gregorian, *Post-Mortem Pregnancy*, 19 ANN. HEALTH L. 401, 424 (2010).
218. *See* J. Rachels, *Active and Passive Euthanasia*, 292 N. ENGL. J. MED. 78 (1975).
219. Vacco v. Quill, 521 U.S. 793, 800–01 (1997).
220. *Id.* at 801.
221. *Id.*

to life-saving blood transfusions based on their religious beliefs. In two cases, courts have ordered blood transfusions to preserve the life of a fetus, even though in one case, the fetus was not yet viable.[222] In another case, the court found the decision was very difficult but ultimately held that "the State may not override a pregnant woman's competent treatment decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus."[223] These cases suggest that a considerable tension exists between a pregnant woman's right to refuse treatment and the state's interest in preserving the life of her fetus. They also demonstrate that courts have previously overridden a woman's autonomy interests in refusing treatment.

Returning to the *Muñoz* case, the family was clear that they and Marlise Muñoz wished to terminate life support.[224] Requiring her to remain on a ventilator against her wishes for weeks on end was a tremendous burden on her constitutional right to withdraw therapy. Does that right still apply to a brain-dead patient who has permanently lost consciousness? There is no reason to think that it would not. The Supreme Court first recognized a fundamental right to withdraw therapy when the individual involved, Nancy Cruzan, was in a persistent vegetative state.[225] Ms. Cruzan had some brain stem function and could breathe without mechanical support, but she had permanently lost consciousness.[226] This suggests that the right to consent or withhold consent from intervention is, at most, slightly diminished for a brain-dead patient. The state's interest in preserving Ms. Muñoz's life was also diminished but not extinguished.

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222. *See* In re Jamaica Hosp., 128 Misc. 2d 1006, 1008 (N.Y. Sup. Ct. 1985) (recognizing that "[i]n this case, the State has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds."); Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson, 42 N.J. 421, 423 (1964) (directing the trial court to undertake the following actions: "(1) to appoint a special guardian for the infant; (2) to substitute such guardian as party plaintiff; (3) to order the guardian to consent to such blood transfusions as may be required and seek such other relief as may be necessary to preserve the lives of the mother and the child; and (4) to direct the mother to submit to such blood transfusions and to restrain the defendant husband from interfering therewith.").

223. In re Brown, 294 Ill. App. 3d 159, 171 (1997).

224. Complaint at 3–4, Muñoz v. John Peter Smith Hospital, No. 096-270080-14 (Tex. 96th Dist. Ct. Jan. 24, 2014), *available at* http://www.thaddeuspope.com/images/Munoz_v._JPS_Jan_2014_.pdf.

225. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 270 (1990).

226. *Id.* at 266–67 n.1.

The hospital and the state should have discontinued Ms. Muñoz's treatment because the fetus was developing abnormally.[227] If the fetus was not going to be born alive, that fact negates any interest the state had in preserving the fetus' life. All of these factors suggest that the hospital and the state should not have kept Ms. Muñoz on life support contrary to her and her family's wishes. In *Muñoz,* then, the legal fiction of brain death led to the same result as a more complex analysis of constitutional rights. But circumstances exist in which the applying the legal fiction of brain death produces a questionable outcome.

Consider a case in which family members of a pregnant, brain-dead patient have evidence that the patient would have wanted to maintain the pregnancy. When family members' interests and the state's interest in preserving the fetus' life align, hospitals and family members may agree to continue to treat a brain-dead, pregnant woman in the hopes that her fetus will remain viable. In those cases, it is hard to imagine why anyone would invoke the legal fiction of brain death.

In other cases, different conflicts could arise. If a pregnant woman were very close to term and became brain dead, but no evidence existed regarding her wishes for the fetus, should she remain on life support? What if the pregnant woman had felt ambivalent about the fetus or had not wanted a child? Likely at some point—not necessarily the point of viability, but some point after the fetus becomes viable—the state's interest in preserving the fetus' life trumps a woman's constitutional right to withdraw therapy. As the pregnancy advances, the woman's interest in withdrawing therapy might be insufficient to overcome the state's interest. The state's interest in preserving fetal life increases depending on the fetus' condition, how far along the pregnancy is, and evidence that the fetus is will survive after birth. Treating brain death as a legal fiction avoids these difficult questions by suggesting that the pregnant woman should be treated as if she were biologically dead and removed from the ventilator.

Finally, ethical questions also arise when brain-dead pregnant women are maintained on mechanical ventilation. Physicians and families have to decide how much effort and resources to expend to try and preserve the fetus' life.[228] Two maternal brain death cases

227. *See* Stipulation of Facts, Muñoz v. John Peter Smith Hospital, No. 096-270080-14 (Tex. 96th Dist. Ct. Jan. 24, 2014), *available at* http://www.thaddeuspope.com/images/MUNOZ_-_Stipulation_Facts.pdf (both parties agreed to the stipulation that the fetus was not viable).

228. If public or pooled resources are used to preserve a fetus, answering how much effort to undertake has even larger implications since more stakeholders have a say.

from the early 1980s demonstrate the complications in deciding whether to try to save the unborn child of a brain-dead mother and how physicians somewhat opaquely take these challenges into account.[229] In the first case, significant questions arose about "the status of the fetus," and the case was very complicated because the mother was never formally declared brain dead.[230] Life support was terminated in this case.[231] In the second case, the fetus was successfully carried to term.[232] Given the relative obscurity around decision-making in cases like these, physicians likely make explicit or implicit judgments about when the medical prospects for a viable fetus are not good enough to try to maintain a pregnant woman[233] and about what costs would be excessive.[234] Physicians should also be cautious about encouraging false hope in families when a fetus might be too early in gestation to survive, and they should clearly inform families about the likelihood that a fetus who survives would suffer from serious morbidities.

C. Other Limits: Research with Brain-Dead Patients

The above Subsection suggests that the legal fiction of brain death does not mechanically extend to new contexts; instead, each extension of the fiction needs a legitimate purpose and must make sense. Other situations may exist in which the legal fiction of brain death may be useful. According to the scholarship on legal fictions, extending a legal fiction beyond its original purposes must be done cautiously since extension into new areas may not make sense. Legal fictions allow existing law to cross boundaries relatively easily and opaquely, and should, therefore, be used sparingly and with clear boundaries. Through briefly touching on biomedical research, an area where it may make sense to use the legal fiction of brain death, this Subsection demonstrates how limiting the legal fiction of brain death might work.[235]

229. Dillon WP et al., *Life Support and Maternal Brain Death During Pregnancy*, 248 J. AM. MED. ASS'N 1089, 1089–90 (1982).

230. *Id.* at 1091.

231. *Id.*

232. *Id.*

233. Siegler & Wikler, *supra* note 132.

234. *See* Anstötz, *supra* note 191, at 342 (describing medical efforts doctors would not take to preserve the life of the fetus).

235. *See* Pernick, *supra* note 59, at 10 (citing Henry K. Beecher, ETHICAL PROBLEMS CREATED BY THE HOPELESSLY UNCONSCIOUS PATIENT, 278 N. ENG. J. MED. 1427, 1430 (1966)) (noting that one of Henry Beecher's motivations for supporting the concept of brain death may have been to find an alternative and less ethically troublesome way of conducting medical research).

Practically, research on brain-dead patients is different than research with biologically-dead people ("cadavers"). Unlike research with cadavers, conducting research with brain-dead individuals could interfere with valuable organ donation. Considerable medical resources are required to maintained brain-dead patients, even for research purposes. There are also important concerns about the disrespectful treatment of individuals who are diagnosed as brain dead, but who are not biologically dead. For example, consider a study testing the effects of explosive land mines on brain-dead bodies.[236] This raises an intuitive reaction of concern or even disgust. These considerations support avoiding the application of the legal fiction of brain death in the research context and a need for more contextual analysis of the specific research projects and the costs they involve.

However, some research with brain-dead patients is easier to justify. One oncology researcher sought to test a method for targeting cancer therapies to particular organs that carried uncertain risks and would require multiple, invasive biopsies.[237] These risks seemed excessive for patients who still might have a meaningful recovery from their cancer and could also take away time spent with their loved ones. Meanwhile, the researcher contacted families of brain-dead cancer patients who knew that their loved ones would have wanted to participate in research that could help others.[238] This research does not raise concerns about reducing the supply of organs available for transplantation to save the lives of others, because organs from metastatic, end-stage cancer patients are not typically used for transplantation based on worries that the organ recipient might develop cancer.[239] Individuals should be allowed to prospectively consent to such research, since concerns about harm to the brain dead patients are reduced.[240] The families of brain-dead patients who did not express their wishes about research when they were capable of making such a decision should be permitted to give proxy consent for research on them.

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236. Jim Ritter, *Ethical Frontier*, CHI. SUN-TIMES (2006) (noting that such research has been conducted with cadavers).

237. Lila Guterman, *Crossing the Line?* 49 Chron. Higher Educ., no. 47, 2003, at A13.

238. *See id.*

239. *See* M.A. Nalesnik et al., *Donor-Transmitted Malignancies in Organ Transplantation: Assessment of Clinical Risk*, AM. J. TRANSPLANTATION, 1140, 1142–45 (2011).

240. *See generally* Miller & Truog, *supra* note 155.

Several scholars have given considerable thought to research on brain-dead patients and have published ethical guidelines for research on people who are brain dead.[241] The existing ethical guidance appears to rely on the legal fiction of brain death without fully acknowledging it.[242] Within existing guidelines, there are provisions that seem to be motivated by concerns that are different from the concerns about research on corpses. For instance, the guidelines suggest a time limit on the research because "[t]he prospect of prolonged storage of ventilated and perfused bodies for research is deemed abhorrent to many and risks undermining public support for research with the recently deceased."[243] In sum, researchers should not use the legal fiction of brain death to determine when research is ethically permissible on brain-dead individuals and instead should separately analyze how to apply the legal and ethical principles governing research to brain-dead participants.

IV. CONSIDERATIONS FOR CREATING AND USING LEGAL FICTIONS

In light of the previous discussion, how should judges and legislators determine when to apply the legal fiction of brain death? Are there limits that would have helped in cases like *McMath* and *Muñoz*? First, highlighting that brain death is a legal fiction is useful because this alerts lawmakers to consider whether brain death is an appropriate standard when they are creating a law that relies upon legal standards for death. Once the legal fiction of brain death is recognized, however, legal actors should not assume that brain death applies by default to new laws that require a determination of death. In drafting statutes that require the continued provision of life-sustaining treatment for pregnant women, the legislature should realize that the statute would, in some cases, require the continued provision of care to brain-dead women whose fetuses are not viable. Then, the legislature should determine whether the statute simply should apply to viable fetuses.

Even in cases that involve viable fetuses, questions remain as to whether a statute that requires life-sustaining treatment for pregnant, brain-dead women, such as in Texas, is constitutional. Cases

241. *See* Rebecca D. Pentz et al., *Ethics Guidelines for Research with the Recently Dead*, 11 NAT. MED. 1145, 1146 (2005) (Table 1) (comparing existing guidelines for research involving the dead—each column of the table cites a different guideline).

242. *Id.* at Table 1.

243. *Id.* at 1148.

involving brain-dead pregnant women require a complicated balancing of the mother's rights against the state's interests, which includes weighing a woman's autonomy and privacy rights and the state's interest in preserving the fetus' life and, to a much lesser extent, the life of a pregnant woman who is not biologically dead. Thus, removing the legal fiction reveals that the Texas statute is constitutionally suspect even for cases involving pregnant women who are not brain dead. Although this is a bolder approach, it is easier for courts to justify and more likely to set the right precedent for future cases. Simply defaulting to the brain death legal standard short-circuits this important, if complicated, analysis.[244]

More generally, the previous analysis suggests that status legal fictions have clear and valuable uses, but that they can also extend beyond reasonable limits. Courts should not adopt a fiction that is likely to spread inappropriately. For instance, Louise Harmon argues that, in its initial case, the fiction of substituted judgment fairly distributed money from a well-off uncle to a needy niece.[245] Yet in future cases, courts used this same legal fiction to justify sterilizing incompetent adults.[246] Harmon is concerned that all legal fictions may eventually be stretched beyond their initial purposes and cause harm, and that it is difficult to predict how this will happen.[247] Thus, she recommends a healthy suspicion towards legal fictions.[248] Harmon does not fully acknowledge, however, that some of the legal fiction's unforeseeable future uses were appropriate and perhaps even beneficial. For instance, using the legal fiction of substituted judgment in the *Cruzan* case led the Court to require clear and convincing evidence for a family to withdraw life-support,[249] implicitly recognize the right to withdraw life-sustaining therapy,[250] and possibly provide room for the law to grow.

Thus, merely identifying harms a fiction causes is not sufficient to condemn its creation or use. Courts should consider both its valuable and harmful uses when they determine whether to create a legal fiction in the first place. Moreover, sometimes it is clear that

244. The court was possibly interested in a pragmatic and fast solution that was unlikely to be appealed and might have thought that a statutory analysis would be harder to challenge. It is difficult to fault the judge in this case but important to note that a different approach could have reached the same outcome and might have set a better precedent.

245. Harmon, *supra* note 107, at 20–21.

246. *Id.* at 27–33.

247. *See* Harmon, *supra* note 107, at 60–63.

248. *See id.* at 70.

249. *Id.*

250. Kenneth P. Miller, *Defining Rights in the States: Judicial Activism and Popular Response*, 76 ALA. L. REV. 2061, 2103 n.44 ("The U.S. Supreme Court has recognized a federal constitutional right for persons to refuse life-sustaining treatment.").

the court needs to use a legal fiction to avoid considerable injustice, and that using that particular legal fiction should be discretionary. If the court can anticipate that the legal fiction might create significant future harms, the author of the fiction should construct it as narrowly as possible.

Predicting the future use of a legal fiction is difficult and stretches beyond the domain of medicine. Medical technology, with its large potential for future development, is just one example of a regime that is difficult to regulate. Another area of rapidly changing jurisprudence is determining which campaign contributions the legislature may prohibit or regulate as speech. Courts should only create legal fictions when the court can delineate the fiction's limits in advance and when the fiction's value is significant enough to risk overextension.

Measuring the value of a legal fiction is also a difficult task and is different for judges and legislators. Legal actors have different available alternatives. Judges generally lack authority to create new legal rules out of whole cloth and are bound by precedent. Legal fictions expand the judges' boundaries in a way that is potentially dangerous. Yet, judges may appropriately create legal fictions where applying the rule seems patently unjust. On the other hand, legislators typically have more discretion to create new rules and are mainly constrained by public perception of the rules. Because legislators have greater authority for rulemaking than judges, they should rarely create or rely on legal fictions.

Those who create legal fictions should seek to limit future expansion. Whenever a legal fiction is created and each time it is extended, the court or legislature should state the fiction's purpose and build limits directly into it. Then, it would be harder for a future court to improperly extend the legal fiction, since the constraints are already in place. For most legal fictions, however, no such process has happened, and judges can easily extend the fiction. Good reasons support making legal fictions more difficult to develop. Legal fictions are very costly to create, given the damage they can cause, and the authors of legal fictions are not sufficiently sensitive to the costs of their creations. Because legal fictions are relatively easy to create and extend, resisting them is more difficult than it should be, given their potential for abuse. Various legal actors should recognize the dangers of legal fictions and provide more careful and clear descriptions the legal fiction's created intent, which will hopefully lead to the more cautious and judicious use of legal fictions.

CONCLUSION

The *McMath* and *Muñoz* cases illustrate how the lack of transparency around the legal fiction of brain death has developed to where the fiction has become overused. Although many scholars have written about different types of legal fictions and the historical basis for them, they have not discussed what happens to legal fictions over time and what characterizes legal fictions that are likely to be misused and overextended. Unacknowledged legal fictions are especially under-recognized and under-studied. Additionally, scholars have not explored what impact the lack of transparency concerning legal fictions has in areas such as public trust or collective action. In this vein, it is unsurprising that courts use legal fictions to determine death, an area fraught with controversy. The legal governance of medical advances is difficult since legal actors must work with medical and scientific experts to understand new medical technologies and how best to regulate them. In some cases, courts may even unwittingly create legal fictions because they fail to understand the implications of new technology. The development of the legal fiction of brain death may serve as a valuable illustration of the useful and pernicious aspects of a legal fiction.

Future scholarship should explore the development of legal fictions and their trajectories over time. Scholars should work to understand when legal fictions likely arise and determine when legal fictions are dangerous enough to diminish or even negate their value. It would also be interesting to study whether legal fictions largely created outside of the legal profession (such as the legal fiction of brain death) have less legitimacy than those fictions judges and legislators construct. Legal fictions are not a historical remnant of the law; they are a legal tool that courts and legislatures are unlikely to abandon. Future scholarship should recognize this, develop a richer understanding of legal fictions, and provide guidance on how legal actors should craft limits on legal fictions.

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TEACHING INTERESTS

Bioethics, International Research Ethics, Health Care Law, Global Health

AWARDS AND HONORS

National Institutes of Health Clinical Center Director's Award for Teaching and Training	2013
Finalist, Mark S. Ehrenreich Prize in Healthcare Ethics Research	2012
Pro bono distinction from Stanford Law School	2005
Outstanding Witness Award, Mock Trial competition	2000

BOARDS AND MEMBERSHIPS

Current

Ethics Consultant, Clinical Sciences Review Committee
Attending, Bioethics Consult Service, Clinical Center, NIH
Member, Clinical Center Ethics Committee
Member, American Society of Bioethics and Humanities
Member, American Bar Association
Member, International Association of Bioethics

Past

Member, International Bioethics Subcommittee, Extramural Scientific Program Management Committee, NIH

BAR ADMISSION

2005 Admitted to California State Bar

SELECTED PRESENTATIONS

June 2014	American Society of Law, Medicine, and Ethics Health Law Professors' Conference, U.C. Hastings College of Law, San Francisco, CA—"Brain Death and the Limits of Legal Fictions."
June 2014	International Association of Bioethics (IAB) Conference, Mexico City—"Responsiveness & Social Value," in Symposium on *The Social Value of Research: Conflicts between Science, Society, and Individuals.*
December 2013	International Symposium on Brain Death and Disorders of Consciousness, Definition of Death Network of IAB, Havana, Cuba—"A legal fictions approach to organ transplantation from brain dead donors."
November 2013	Pan American Health Organization, World Health Organization, Washington, DC, USA—"Ethical trade-offs in trial design."
May 2013	NIAID, Workshop on Tuberculosis in Children and Pregnant Women, Bethesda, MD—"Towards Earlier Ethical Involvement of Children in Trials of New Tuberculosis Drugs."
May 2013	International Maternal Pediatric Adolescent Clinical Trials Network Annual Meeting, Washington, DC—"An ethical path to curing HIV in children?"
June 2012	IAB Meeting, Rotterdam, Netherlands—"Is Pediatric Research Legally Unsound?"
June 2012	IAB Meeting, Rotterdam, Netherlands—"The Future Targets of Bioethics: Institutions in Research Ethics?"
December 2011	Post-Trial Access to Trial Drugs: Legal, ethical, and practical issues, Brocher Foundation, Geneva, Switzerland –"The Responsible Termination of Research."
October 2011	American Society of Bioethics and Humanities Meeting, Minneapolis, MN—"Data on Compensation for Research Related Injury: How much will it cost?"
June 2011	Bowie State University, Bowie, MD—"The Ethics of Pediatric Research."
July 2010	Fogarty Scholars' Meeting, Bethesda, MD—"The Responsiveness Requirement."

June 2010	IAB Meeting, Singapore—"The Responsiveness Requirement."
June 2009	FDA Center for Drug Evaluation and Research, Annual Meeting, Bethesda, MD—"A Legal or Ethical Right to Access Unapproved Therapy?"

WORKSHOPS/TRAINING ACTIVITIES

2007-present	Organize, moderate, and present at "Advanced Research Ethics Workshop" at Annual Professional Responsibility in Medicine & Research (PRIM&R) conference.
2006-present	Teach individual classes and lead training sessions at the National Institutes of Health, including: Clinical Center Ethical & Regulatory Aspects of Human Subjects Research, Department of Bioethics Seminar on Introductory Bioethics, and Division of AIDS ethics workshops.
2006-present	International workshops on research ethics for health researchers, ethics committee members, and government officials in countries including China, Mali, Vietnam, Philippines, Singapore, Peru, Indonesia, Japan.

Docket No. 17-17153

In the

United States Court of Appeals

For the

Ninth Circuit

JONEE FONSECA, an individual parent and guardian of I.S., a minor and LIFE LEGAL DEFENSE FOUNDATION,

Plaintiffs-Appellants,

v.

KAREN SMITH, M.D. in her official capacity as Director of the California Department of Public Health,

Defendant-Appellee.

Appeal from a Decision of the United States District Court for the Eastern District of California, No. 2:16-cv-00889-KJM-EFB · Honorable Kimberly J. Mueller

EXCERPTS OF RECORD
VOLUME IV OF V – Pages 543 to 801

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION; MEMORANDUM IN SUPPORT** **Date:** May 11, 2016 **Time:** 3:30 p.m. **Ctrm:** 3 **Hon.:** Kimberly J. Mueller

[1] *Counsel of record*

NOTICE OF MOTION AND MOTION

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD HEREIN

PLEASE TAKE NOTICE that on May 11, 2016, at 3:30 p.m., this matter is set to be heard in Courtroom 3 of this Court on the 15th Floor, located at 501 I Street Sacramento, CA 95814. Pursuant to Rule 65 of the Federal Rules of Civil Procedure and Civil Local Rules 65-2, Plaintiff, Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, by and through her counsel, will and hereby does, move this Court to supersede the temporary restraining order now in place by a preliminary injunction restraining Defendant, Kaiser Permanente Medical Center Roseville, and all persons acting at its behest or direction.

This Motion is made on the grounds that Plaintiff is likely to succeed on the merits and irreparable injury will result if life-support is removed from Israel Stinson. In addition, the balance of hardships weighs sharply in Plaintiff's favor, and it is in the public interest that a preliminary injunction be issued.

This Application is based on this Notice of Motion and Motion, the Amended Complaint For Injunctive And Declaratory Relief, the Memorandum of Points and Authorities, the declarations and exhibits and other papers previously filed with the Court and on such further evidence and argument as may be presented at the hearing.

Respectfully submitted on this sixth day of May, 2016.

S/ Kevin T. Snider_____
Kevin T. Snider

Attorney for Plaintiff

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INTRODUCTION & SUMMARY OF THE ARGUMENT

Counsel for Plaintiff, Jonee Fonseca ("Ms. Fonseca") submits this Motion pursuant to the Court's order of May 2, 2016, and the initial granting of the Temporary Restraining Order. This continues to be an extraordinarily time-sensitive case seeking to preserve life-support for toddler Israel Stinson. In her Amended Complaint filed May 3, Ms. Fonseca has dropped her First Amendment, ADA and Rehabilitation Act claims. Plaintiff has added, though, significant new claims based on privacy, due process and the Emergency Medical Treatment and Active Labor Act. The refinement of Ms. Fonseca's claims provide a solid foundation for the Court to grant the preliminary injunction that would extend life-sustaining treatment for Israel.

FACTS[2]

On April 1, 2016, Ms. Fonseca took Israel to Mercy General Hospital ("Mercy") with symptoms of an asthma attack. Upon examination in the emergency room, he was placed on a breathing machine. Shortly thereafter he began shivering, his lips turned purple, eyes rolled back and he lost consciousness. He had an intubation performed on him. Doctors then told Ms. Fonseca they had to transfer Israel to the University of California Davis Medical Center, Sacramento ("UC Davis") because Mercy did not have a pediatric unit. Taken by ambulance to UC Davis, he was admitted to the pediatric intensive care unit.

The next day the tube was removed. The respiratory therapist said that Israel was stable and that he could possibly be discharged the following day, April

[2] The facts are set forth in detail in the Amended Complaint and the declarations previously filed with the Court. Additionally, Ms. Fonseca is available to testify at the hearing.

3. The doctors at UC Davis put Israel on albuterol for one hour, and then wanted to take him off albuterol for an hour. About 30 minutes later while off albuterol, Israel's mother noticed that he began to wheeze and have trouble breathing. The nurse came back in and put Israel on the albuterol machine. Within a few minutes the monitor started beeping. The nurse came in and repositioned the mask on Israel, then left the room. Within minutes of the nurse leaving the room, Israel started to shiver and went limp in his mother's arms. She pressed the nurses' button, and screamed for help. A different nurse came in, and Ms. Fonseca asked to see a doctor.

Dr. Meteev came to the room and said she did not want to intubate Israel to see if he could breathe on his own without the tube. Because Israel was not breathing on his own, doctors performed CPR and were able to resuscitate him. Dr. Meteev told Ms. Fonseca that Israel was "going to make it" and that he would be put on ECMO[3] to support his heart and lungs.

That day a brain test was conducted to determine the possibility of brain damage while he was hooked up to a ECMO machine. The following day the same tests were performed when he was taken off the machine. On April 6, Israel was taken off ECMO because his heart and lungs were functioning on their own. The next day, a radioactive test was performed to determine blood flow to the brain. A UC Davis physician performed a brain death exam on April 8, pursuant to the California Uniform Determination of Death Act ("CUDDA").

On April 11, 2016, Israel was transferred via ambulance from UC Davis to Defendant Kaiser Permanente Roseville Medical Center -- Women and Children's Center ("KPRMC") for additional treatment. Upon his arrival at KPRMC, another

[3] Extracorporeal Membrane Oxygenation

reflex test was done, in addition to an apnea test. On April 14, 2016, an additional reflex test was performed for determination of brain death in conjunction with the CUDDA protocol. That same day a Certificate of Death, provided by the California Department of Public Health, was issued.

The family was notified by KPRMC as per the State's directive found in Health and Safety Code §1254.4. The State of California requires KPRMC to adopt a policy for providing family or next of kin with a reasonably brief period of accommodation to gather family at the bedside of the patient after declaration of death, pursuant to CUDDA.

With pulmonary support provided by the ventilator, Israel's heart and other organs continue to function well. Israel has also begun moving his upper body in response to his mother's voice and touch. Nonetheless, Israel has undergone certain tests which have demonstrated brain damage from lack of oxygen. He is totally disabled at this time and is severely limited in all major life activities. Other than the movements in response to his mother's voice and touch, he is unable to feed himself or do anything of his own volition.

Defendant Dr. Myette, has informed Ms. Fonseca that Israel is brain dead, utilizing the definition of "brain death" derived from CUDDA. Israel's mother and father are Christians with firm religious beliefs that as long as the heart is beating, Israel is alive. Based upon CUDDA, KPRMC has informed Ms. Fonseca that it intends to imminently disconnect the ventilator that Israel is relying upon to breath. Ms. Fonseca has contacted three physicians outside of the KPRMC system for second opinions.[4] Based upon CUDDA, KPRMC claims that, since its

[4] See the declarations of Drs. Paul Byrne (Ct. doc. 3-1), Thomas Zabiega (Ct. doc. 21, 21-1 & 21-2), and Peter Mathews (Ct. doc. 15).

medical doctors have pronounced Israel brain dead, Ms. Fonseca has no right to exercise any decision making authority.

Ms. Fonseca has repeatedly asked that her child be given nutrition, including protein and fats. She has also asked that he be provided nutritional feeding through a nasal-gastric tube or gastric tube to provide him with nutrients as soon as possible. She has also asked for care to be administered to her son to maintain his heart, tissues, organs, etc. KPRMC has refused to provide such treatment stating that they do not treat or feed brain dead patients. They have denied her ability to make decisions over the health care of her son. Ms. Fonseca has sought alternate placement of her son, outside the KPRMC's facility. To this end she has secured transportation and is seeking alternative placement but requires time for that to occur. If KPRMC proceeds with its plans, Israel will expire.

KPRMC and UC Davis physician's were not exercising autonomous professional judgment. Instead, they were acting jointly, and/or on behalf of the State by carrying out the function of determining death in a manner that the State prescribes under CUDDA.

Since the issuance of the death certificate, Israel has shown movement in direct response to the voice and touch of his mother. He has taken breathes off of the ventilator. Further, two physicians, independent of KPRMC and UC Davis, have raised concerns that Israel may in fact be alive and would improve with treatment. In that there is a dispute of fact between medical doctors, Israel's mother believes that she has a moral and spiritual obligation to give her child the benefit of the medical doubt.

Officials with the State have jointly participated with KPRMC in

implementing the policies and procedures surrounding the determination and processing of Israel's death under CUDDA.

ARGUMENT

I. THE COURT HAS ARTICLE III JURISDICTION

a. The Amended Complaint raises federal questions under the Emergency Medical Treatment and Active Labor Act.

In the Amended Complaint, Ms. Fonseca has added a crucial claim under 42 U.S.C. 1395dd et seq., the Emergency Medical Treatment and Active Labor Act ("EMTAALA"). Following the initial, emergency filing of the Complaint on April 28, it has become clear to Plaintiff's counsel that the EMTAALA has significant bearing on this case, as is more fully explained in Section II(a)(i)(1) below. The EMTAALA provides federal question jurisdiction to the Court as well as an independent, statutory basis for injunctive relief.

b. The Amended Complaint now includes a State Defendant and challenges the constitutionality of a California Act.

The Amended Complaint also now directly challenges the constitutionality of CUDDA. The suit adds as a defendant the state official in charge of the Department of Public Health, Dr. Karen Smith. As more fully set forth below, the statute violates due process by providing no avenues of appeal of a life-and-death decision. The constitutionality of the statute is a federal question squarely before the Court.

c. The conduct of KPRMC under CUDDA constitutes state action.

Lastly, the actions of KPRMC that Ms. Fonseca seeks to enjoin can be characterized as state action subject to constitutional safeguards, even in the

absence of the EMTAALA, the State defendant, and the direct constitutional challenges to the underlying statute.

The Supreme Court and Ninth Circuit have addressed state action on a number of occasions, leading to some fine distinctions. To be sure, state regulation of an industry is not enough to establish state action. *Jackson v. Metro. Edison Co.*, 419 U.S. 345 (1974); *Blum v. Yaretsky*, 457 U.S. 991 (1982). Plaintiff is therefore not arguing that regulation alone transforms KPRMC into a state actor. Rather, it is the coercive nature of the challenged statute and the degree to which the state and KPRMC are entwined in these types of life-and-death decisions.

The Court explained in *Blum* that coercive statutes could transform healthcare decision-making into state action. There was no state action because the patients in *Blum* did "not challeng[e] particular state regulations or procedures." *Blum*, 457 U.S. at 1003 (emphasis added). *Blum* rejected a broader claim that the regulatory system itself created state action. The Court was not willing to turn heavily-regulated industries like healthcare, comprising 1/6 of the national economy, into state actors for all purposes. However, the Court opened the door to state action in limited circumstances involving coercive statutes.

Here, KPRMC has sought to defend its actions by making just such a claim. KPRMC's attempt to deflect responsibility onto CUDDA reinforces the reality that declarations of death are essentially a state-prescribed function. Unlike in *Blum*, under these facts before this Court, the State is responsible for the specific conduct of which Plaintiff complains. *Blum*, 457 U.S. at 1004. CUDDA is in no way like the utility company whose conduct was merely "permissible under state

law." *Jackson*, 419 U.S. at 358. Instead, there is an extremely "close nexus between the State and the challenged action." *Id.*, 351.

In the present matter, the State has "exercised coercive power or has provided such significant [overt] encouragement" that the actions of KPRMC are to be deemed that of the State. *Brentwood Acad. v. Tenn. Sch. Ath. Ass'n*, 531 U.S. 288, 297 (2001). The State, through CUDDA, is not merely approving or acquiescing to the independent judgment of medical professionals relative to Israel. *Flagg Bros. v. Brooks*, 436 U.S. 149, 164 (1978).[5] Thus, KPRMC's conduct is rightly understood as performed under color of law.

Under *Lugar v. Edmonson Oil Co.*, 457 U.S. 922 (1982), the Supreme Court explained that "state action" is present when a private actor operates as a "willful participant in joint activity with the State or its agents." *Id.*, at 941. In acting pursuant to CUDDA, such describes the conduct of KPRMC. CUDDA defines *death*. Health & Safety Code §7180. KPRMC has no discretion to entertain independent medical judgment inconsistent with CUDDA's definition. CUDDA prescribes the protocol for confirmation of *death*. Health & Safety Code §7181. KPRMC undertakes to perform the confirmation of brain function cessation as per CUDDA. Under CUDDA, a medical facility must then record, communicate with government entities, and maintain records relative to the "irreversible cessation of all functions of the entire brain." Health & Safety Code §7183. Such includes

[5] *See also*, the concurrence of Justice White in *Rendell-Baker v. Kohn*, 457 U.S. 830, 843 (1982), in which he compares private employment decisions with independent medical decisions. Also, in *Rendell-Baker* employees claimed that a private school's employment decisions were state action because a large portion of funding and student referrals came from Massachusetts. That was rejected by the high court and that rationale is not offered here.

filling out portions of the Certificate of Death provided by the Department of Public Health within 15 hours after death under (Health & Safety Code §102800) and that KPRMC register the death with local officials (Health & Safety Code §102775).

It is not necessary in this case for the Court to designate KPRMC as a state actor for all purposes. Indeed, the Court should decline to so rule. *Safari v. Kaiser Found. Health Plan*, 2012 U.S. Dist. LEXIS 67059 (N.D. Cal. May 11, 2012).[6]

It has become clear that individuals may be considered state actors for limited purposes even when much of their conduct would not be attributable to the State. For instance, in *West v. Atkins*, 487 U.S. 42 (1988), a doctor who was an independent contractor was deemed a state actor in his delivery of services to prison inmates. And in *Chudacoff v. Univ. Med. Ctr.*, 649 F.3d 1143 (9th Cir. 2011), the physicians' status as independent decision-makers did not shield their conduct from being considered state action when their authority to make the challenged employment decision ultimately derived from the state. KPRMC need not be a state actor across the board – the death decision is uniquely derivative of a coercive state statute, and it should be treated as such.

Additionally, the Supreme Court held in *Brentwood Academy*, that private entities may be so entwined with the government that decisions become state action. Id., 531 U.S. at 303. Here, KPRMC received Israel from one public institution, the UC Davis Medical Center, and is attempting to hand him over to another public official, the coroner. The State prescribes the condition under

[6] Although *Safari v. Kaiser* is unpublished, the Court has brought this case to the attention of the parties at the May 2, 2016, hearing.

which both of these transfers take place. Few medical decisions receive the level of involvement and interest that the State takes in the declaration of death, and for good reason. The State's interest in the preservation of life is at the apex of governmental interests. The declaration of death should therefore be declared state action because it is orchestrated by KPRMC via CUDDA.

In sum, the Court has Article III jurisdiction for three reasons: the Amended Complaint pleads a cause of action under the federal EMTAALA; the Amended Complaint now directly challenges the constitutionality of a statute and names the state official responsible for enforcement of that statute; and the declaration of death should be deemed state action under both the coercion and entwinement aspects of state action jurisprudence.

II. A PRELIMINARY INJUNCTION IS CRUCIAL TO PRESERVE THE STATUS QUO

a. Standard Of Review

The standard for granting a preliminary injunction is set forth in *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20-22 (2008). Under *Winter*, a preliminary injunction should be granted upon a clear showing by the plaintiff that "he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest."

i. Plaintiff Is Likely To Succeed On The Merits

The likelihood of success standard is met when there are serious questions going to the merits. *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1132 (9th Cir. 2011). "It will ordinarily be enough that the plaintiff has raised questions going to the merits so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberative investigation." *Hamilton*

Watch Co. v. Benrus Watch Co., 206 F.2d 738, 740 (2d Cir. 1953) (quoted in *Republic of Philippines v. Marcos*, 862 F.2d 1355, 1362 (9th Cir. 1988) (en banc)).

1. The facts of the case fall under EMTAALA.

Pursuant to EMTAALA, the Amended Complaint alleges that KPRMC is a participating hospital subject to the statute; that it received Israel in an emergency medical condition; that it is now seeking to de-stabilize his condition by turning off his ventilator and removing all life support; that KPRMC's proposed actions will cause material deterioration of Israel's condition; and that both he and his mother will experience grave personal harm from KPRMC's action if they are not enjoined.

The leading case applying EMTAALA to a severely disabled child like Israel is *In re Baby K*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 1994 U.S. Lexis 5641. The facts of that case have striking similarities to the present. Baby K was born with a diagnosis of encephala, with no cerebrum, permanently unconscious with no cognitive awareness or ability to interact with her environment. *Id.* at 592. Baby K was initially kept alive by a ventilator for diagnostic purposes. *Id.* After the mother resisted the hospital's recommendation that no further breathing support be provided, Baby K was transferred to a nursing home. She was readmitted to the hospital three times with respiratory problems. *Id.* at 593. The hospital filed suit seeking a declaratory judgment that it was not obligated to provide further respiratory treatment to Baby K that it considered futile. *Id.*

The main thrust of the hospital's argument was that EMTAALA should not be interpreted to require it or its physicians to provide treatment they deemed medically and ethically inappropriate. *Id.* Expanding on this argument, the

hospital insisted Congress could not have intended to require it to provide futile treatment that exceeded the prevailing standard of care. The court disagreed, holding that "stabilizing treatment" was required under EMTAALA, and the court was without authority to rewrite the unambiguous language of the statute. *Id.* at 596. In sum, the court could not approve withholding of respiratory assistance, including a ventilator, that would cause material deterioration of Baby K's condition in violation of EMTAALA. *Id.* at 595-96.

The West Coast does not appear to have had a case as similar to the present as *Baby K*, but the Ninth Circuit cited it approvingly in *Eberhart v. Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) (addressing screening provisions of EMTAALA).

Under its plain terms, as pled in the Amended Complaint, EMTAALA requires KPRMC to provide Israel with stabilizing treatment that will prevent his material deterioration while in the hospital's care. In this case, as with Baby K, that means a ventilator and (as the hospital conceded in that case) warmth, nutrition and hydration. Under the statute, the hospital has the option of transferring Israel if such transfer can be accomplished without his material deterioration. This is exactly what Ms. Fonseca has been seeking.

EMTAALA certainly raises serious questions; arguably, it goes beyond that, and the leading case on this issue makes it likely Ms. Fonseca will ultimately prevail on the merits. The requested injunctive relief should therefore be issued.

2. Serious questions are raised as to whether CUDDA is consistent with substantive and procedural due process.

"No State shall make or enforce any law which shall…deprive any person of life…without due process of law." U.S. Const., Amendment XIV. In *Washington v. Glucksberg*, 521 U.S. 702 (1997), the Supreme Court declined to

create a fundamental right to hasten one's death, in large part because the American tradition has long recognized the opposite – the highest interest in preserving life. *Id.* at 728. "As a general matter, the States – indeed, all civilized nations – demonstrate their commitment to life." *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 280 (1990). The challenged statutes purport to both reverse the fundamental presumption that life should be protected and preserved if at all possible, and (as will further be seen in the next section) takes away the fundamental rights of fit parents to make major medical decisions for their young children.

Plaintiff brings a facial challenge to a statutory scheme relative to the death event. KPRMC has noted – correctly – that "historically, death has been defined as the cessation of heart and respiratory functions." Kaiser Brief at p. 10 (Ct. doc, 14). California's statutory scheme broadens the definition of *death*. Under section 7181 determination as to whether a person has sustained an irreversible cessation of all functions of the entire brain is made by "independent confirmation of another physician." Under CUDDA, neither the patient nor the patient's representative is provided any mechanism to challenge the findings. This is true whether or not the patient's representative both understands and agrees with the State's definition of *death*. In the present case, Ms. Fonseca wishes to bring in her own physician to examine Israel. KPRMC will not consent to such, for nothing on the face of the text would indicate that the independent physician be someone chosen by the family of the patient. At this stage of the proceedings, Plaintiff is not asserting that KPRMC has misread or misapplied CUDDA.

CUDDA provides no opportunity for Israel's mother to be heard. "The opportunity to be heard must be tailored to the capacities and circumstances of

those who are to be heard." *Goldberg v. Kelly*, 397 U.S. 254, 268-69 (1970). If such is true for the receipt of welfare benefits under *Goldberg*, how much more so when the matter at issue is the loss of life.

The essence of due process is the requirement that "a person in jeopardy of serious loss [be given] notice of the case against him and opportunity to meet it." *Joint Anti-Fascist Comm. v. McGrath*, 341 U.S. 123, 171-172 (1951) (Frankfurter, J., concurring). Here the statutory scheme expedites the determination of *death* by not including cessation or breathing and heartbeat within the definition. This lessoned standard of *death* provides no process by which the patient's advocate can obtain a different independent medical opinion by the physician of her choosing or even challenge the findings. This raises a serious question of law which requires that the status quo be preserved until resolved.

3. Serious questions are raised as to the authority of the State to overrule a fit parent on major medical decisions for her child.

The Plaintiff further challenges CUDDA because a parent naturally has a profound emotional bond with her child. In addition to that, this parent – Ms. Fonseca – believes she has a moral and spiritual obligation to give her child every benefit of the doubt before disconnecting life support. "The choice between life and death is a deeply personal decision of obvious overwhelming finality." *Cruzan*, 497 U.S. at 281. In the present case, the facts are that the parent has a sincerely held religious belief that life does not end until the heart ceases to beat. Moreover, Israel responds to her voice and touch.[7] On occasion, Israel has taken

[7] Declaration of Alexandra Snyder regarding Video Footage, Photo And Movement Exhibited By Israel Stinson ¶¶2-5 (Ct. doc. 18)

breathes on his own.[8] Additionally, the facts are that a physician believes that the child is not dead[9] and Israel's condition can improve with further treatment.[10]

Typically, a fit parent has plenary authority over medical decisions for a small child. As stated above and further articulated in her pro per filings in the Superior Court, Ms. Fonseca has a moral and spiritual obligation to give her child every benefit of the medical doubt as to whether the child is in fact dead or can improve with additional treatment.

In rare situations, the courts have allowed the State to intervene to administer treatment to a child when the parent refuses treatment. *In re Long Island Jewish Med. Ctr.*, 147 Misc.2d 724 (N.Y. Supreme Ct. 1990) (ordering blood transfusions for 17-year-old cancer patient against his will). It is a tragic irony that here, the hospital is refusing treatment and the parent is fighting for treatment. In such a case, the Court should be no less willing to authorize life-sustaining treatment for the child.

However, KPRMC is bound by the State scheme for a death event. The scheme excludes this parent from any due process in the decision making. This raises serious legal questions under the standard set forth in *Alliance for the Wild Rockies*, 632 F.3d at 1132.

In *Family Independence Agency v. A.M.B.* (*In re AMB*), 248 Mich. App. 144 (Mich Ct. App. 2001), the appellate court conducted an extensive post-mortem of the circumstances surrounding the withdrawal of life support from Baby Allison. Baby Allison's life and death landed in Family Court because

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[8] Id.
[9] Declaration of Paul A. Byrne, M.D., p. 4, ¶15.
[10] Id. at ¶12.

Allison's teenage mother was severely mentally challenged, and the child had apparently been conceived through incest and rape perpetrated by her father, who was incarcerated as soon as this was suspected.

The appellate court found serious due process violations in the manner that the decision to end Baby Allison's life was taken away from her parents. "If the facts surrounding Baby Allison's conception are tragic, the circumstances leading to her death are doubly so. Through unredeemably flawed Family Court proceedings, the Family Independence Agency (FIA) acquired what appeared to be an order that authorized Children's Hospital staff to take the child off life support equipment and medication provided that comfort care is provided." Although the order gave 7 days for the parties to appeal, life support was ended the next day at the direction of the mother's aunts, and she died within 2 hours. *Id.* at 150.

The Family Court authorized the termination of life support after a doctor testified by phone that being on the ventilator was not in the child's best interests because its deformed heart could not support long-term survival. *Id.* at 160.

Although the court's order stated that it would take effect in 7 days, during which time an appeal could be filed, it was carried out the next day. The attorney appointed for Baby Allison filed an appeal within the week specified by the court, but it was too late since the order was executed prematurely. *Id.* at 161-62.

On appeal, the court sought to prevent future tragedies and received considerable *amicus* input. The court considered a number of statutes governing the authority of the Family Court and other arguments for reversal, including the EMTAALA and the ADA. Ultimately, the court zeroed in on the presumption that to establish incompetency for the parent who would otherwise have a

Fourteenth Amendment liberty interest in making medical decisions for their child, the evidence must be clear and convincing. *Id*. at 204-5.

"Any lower evidentiary standard brings with it a potential for abuse leading to irreparable harm because there typically is no adequate remedy for an erroneous order withdrawing life support." *Id.* at 204-5. "Further, making a decision to withdraw life support is so serious that it is unlike any other decision a Family Court has to make." *Id.* at 205.

Thus, the court held that, even though circumstantial and hearsay evidence pointed to the parents' inability to make life-and-death decisions for their child, much more formal adjudication of the parents' incompetence was required to take away the decision from them. *Id.* The same is much more true here, where Ms. Fonseca's fitness is not in question and KPRMC is seeking to take away this mother's ability to make this monumental decision for her child. The irreparable harm recognized by the Michigan Court of Appeals that inheres in the decision to terminate life support for a child weighs strongly in favor of granting the preliminary injunction to ensure adequate adjudication, consistency with due process and deference to parental rights under the Fourteenth Amendment.

ii. Israel Will Suffer Irreparable Harm If Life-Support Is Removed.

The Fourteenth Amendment guarantees that "[n]o State shall make or enforce any law which shall…deprive any person of life…without due process of law." The Clause provides "heightened protection against government interference with certain fundamental rights and liberties." *Glucksberg*, 521 U.S. at 720. It is well established that the loss of core constitutional freedoms, for even minimal periods of time, constitutes irreparable harm. *Elrod v. Burns*, 427 U.S.

347, 373 (1976).

If the Court determines there is no state action present, the harm of loss of life is nonetheless irreparable even at the hand of a private actor. No amount of monetary damages or other corrective relief during the course of litigation is adequate. *Los Angeles Memorial Coliseum Com. v. National Football League*, 634 F.2d 1197, 1202 (9th Cir. 1980). In view of that, this Court can exercise equitable powers to maintain the status quo under the non-1983 claims.

iii. The Balance Of Hardships Tips Sharply In Favor Of The Plaintiff.

A preliminary injunction should supersede the temporary restraining order. If the TRO is dissolved, it is highly probable that all of Israel's organs will quickly cease to function. He will be dead – under any medical definition of the word. But if the status quo remains in place while factual and legal issues are resolved during this suit, Israel's organs will continue to function and his parents can continue to seek placement for him in an institution that is not bound by CUDDA. In balancing the hardships, neither KPRMC – or its agents – die nor will they suffer the loss of a child. In the factual dispute between KPRMC and Ms. Fonseca's physicians who question KPRMC's findings, an error by the latter will render little harm – if any. In stark and profound contrast, if KPRMC is in medical error, Israel will have lost his life without due process of law. The Supreme Court explained:

> An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science,…changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous

> decision to withdraw life-sustaining treatment, however, is not susceptible of correction. *Cruzan*, 497 U.S. at 283.

In view of that, a decision to "discontinue hydration and nutrition of a patient" is irrevocable. Id.

Thus, in weighing the respective interests of the parties on the scales of justice, the balance of hardships tips heavily in favor of the Plaintiff. *Winter,* 555 U.S. at 20-22.

iv. An Injunction Against KPRMC Is In The Public Interest.[11]

The "general public has an interest in the health" of state residents. *Golden Gate Rest. Ass'n v. City of San Francisco*, 512 F.3d 1112, 1126 (9th Cir. 2008). If such is the case for health, it is all the more so for life. Unquestionably, public policy favors the preserving of life. *United States v. Ferron*, 2013 U.S. Dist. LEXIS 93962 (D. Ariz. July 3, 2013). As the Supreme Court explained in an end-of-life case, "We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute." *Cruzan*, 497 U.S. at 283.

Even if there was conceivably some reason why there is no public interest in due process regarding Israel, such would not be dispositive. A preliminary injunction in this case would be limited to this child. At this conjuncture, Plaintiff is not seeking a declaration that CUDDA is unconstitutional. Further, this case is not brought as a class action. See generally *Zepeda v. INS*, 753 F.2d 719, 727-28 (9th Cir. 1984) ("A federal court may issue an injunction if it has personal jurisdiction over the parties and subject matter jurisdiction over the claim; it may

[11] The Court need not reach this inquiry because the public interest can be subsumed in the balancing of the hardships prong. *Caribbean Marine Servs. Co. v. Baldrige*, 844 F.2d 668, 674 (9th Cir. 1980).

not attempt to determine the rights of persons not before the court. . . . The district court must, therefore, tailor the injunction to affect only those persons over which it has power."

III. THE ROOKER-FELDMAN DOCTRINE DOES NOT APPLY.[12]

Because of the prior actions taken by the Superior Court to preserve Israel's life, this Court has raised concerns as to whether the *Rooker-Feldman* doctrine bars jurisdiction. It does not.

In one of its more recent decisions expounding on *Rooker-Feldman*, the Supreme Court explained that the doctrine serves to prevent losers of state court actions from asking the federal courts to act as *de facto* appellate courts in reviewing the adverse state court judgment. *Exxon-Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280 (2005). It has no bearing where, as here, Ms. Fonseca did not lose in state court – she obtained a temporary restraining order – and this Court is not being asked to reconsider or reverse any aspect of the Superior Court's actions. *Bianchi v. Rylaarsdam*, 334 F.3d 895, 898 (9th Cir. 2003).

The Ninth Circuit has explained that *Rooker-Feldman* "applies only when the federal plaintiff both asserts as her injury legal error…by the state court *and* seeks as her remedy relief from state court judgment." *Kougasian v. TMSL, Inc.*, 359 F.3d 1136 (9th Cir. 2004) (emphasis in original). Neither of those two elements is in play in the present case.

[12] *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923) and *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983).

CONCLUSION

Plaintiffs have raised serious legal questions. Because disruption of the status quo would be profound and irreversible, the equities tip sharply in Israel's favor.

Respectfully submitted on this sixth day of May, 2016.

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S/ Matthew McReynolds_____
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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **[PROPOSED] ORDER SUPERSEDING TEMPORARY RESTRAINING ORDER WITH PRELIMINARY INJUNCTION** **Date:** May 11, 2016 **Time:** 3:30 p.m. **Ctrm:** 3 **Hon.:** Kimberly J. Mueller

The matter in the above-encaptioned case came before this Court on May 11, 2016, to consider the motion by Plaintiff, Jonee Fonseca, an individual parent and guardian of Israel Stinson, to supersede the temporary restraining order now in place with a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure and Civil Local Rules 65-2. Mr. Kevin Snider of Pacific Justice Institute appeared on behalf of Plaintiff. Mr. Jason Curliano of Buty & Curliano appeared on behalf of Defendants, Kaiser Permanente Medical Center Roseville, and Dr. Michael Myette, M.D.

Having considered the papers filed by the parties and argument by counsel, the Court finds as follows:

Under the sliding scale test for preliminary injunctions (Fed. Rule Civ. Proc. 65) set forth in *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127 (9th Cir. 2011), the Plaintiff has demonstrated: (1) a likelihood of success on the merits by raising serious; (2) a significant threat of irreparable injury to Israel Stinson if life-support is disconnected; (3) that the balance of hardships favors continued use of life-support for the child; and, (4) that the public interest favors granting an injunction. Therefore, in weighing all four requirements under Rule 65, the Court finds that absent preservation of the status quo, Plaintiff will suffer profound injury hence tipping the respective interests between the parties sharply in her favor.

The motion to supersede the temporary restraining order with a preliminary injunction is GRANTED.

The Court hereby further orders as follows:

a. Defendant, Kaiser Permanente Medical Center Roseville shall be

restrained from removing ventilation from Israel Stinson;

b. Defendant, Kaiser Permanente Medical Center Roseville shall continue to be legally responsible for Israel Stinson's care and treatment;

c. Defendant, Kaiser Permanente Medical Center Roseville shall continue to provide cardio-pulmonary support as is currently being provided;

d. Defendant, Kaiser Permanente Medical Center Roseville shall continue to provide medications administered to Israel Stinson and any other medications necessary for routine maintenance and treatment; and,

e. Defendant, Kaiser Permanente Medical Center Roseville shall continue to provide nutrition to Israel Stinson including hydration, proteins, fats, and vitamins to the extent medically possible to maintain his stability and prevent deterioration in health, given his present condition.

These orders shall remain in effect until further order of this Court.

IT IS SO ORDERED.

Dated: May 11, 2016

Kimberly J. Mueller
United States District Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **DECLARATION OF JONEE FONSECA REGARDING VIDEO RECORDING OF ISRAEL STINSON**

DECLARATION OF JONEE FONSECA

I, Jonee Fonseca, am the plaintiff in the above-encaptioned case and if called upon, I could and would testify truthfully, as to my own person knowledge, as follows:

1. I am Israel Stinson's mother.

2. On May 3, 2016, I recorded two videos showing Israel's purposeful response to my voice alone, without me touching him. These videos are a true and correct representation of Israel's movements.

3. The videos are available at:

https://youtu.be/rxOSv1DMyrI

https://youtu.be/AzQTzPgKgXw

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 6th Day of May, 2016.

_S/ Jonee Fonseca
Jonee Fonseca, Plaintiff

Guidelines for Brain Death in Children: Toolkit

These guidelines and toolkit are based upon the available literature and consensus opinion of a panel of national experts, and may differ from individual state laws or statutes, as well as individual hospital policies and procedures. Please review all relevant hospital and state policies and regulations when utilizing the Society of Critical Care Medicine guideline and toolkit in the assessment and declaration of brain death in children. Please use the Alt + Left Arrow to return to previous view.

Tab 1: Index

1. Revised pediatric guidelines for determination of brain death in children:
    a. Guidelines for the determination of brain death in infants and children: an update of the 1987 task force recommendations. *Crit Care Med*. 2011; 39(9):2139–2155. http://journals.lww.com/ccmjournal/Fulltext/2011/09000/Guidelines_for_the_determination_of_brain_death_in.16.aspx
    b. Guidelines for the determination of brain death in Infants and children: an update of the 1987 task force recommendations. *Pediatrics.* 2011; 128(3):e720-e740. http://pediatrics.aappublications.org/content/early/2011/08/24/peds.2011-1511
    c. Guidelines for the determination of brain death in infants and children: an update of the 1987 task force recommendations — Executive Summary. *Ann Neurol*. 2012; 71(4):573–585.

Endorsing organizations:

American Academy of Pediatrics:
Section on Critical Care
Section on Neurology
American Association of Critical Care Nurses
Child Neurology Society
National Association of Pediatric Nurse Practitioners
Society of Critical Care Medicine
Society for Pediatric Anesthesia
Society of Pediatric Neuroradiology
World Federation of Pediatric Intensive and Critical Care Societies

Affirmed the value of the manuscript:

American Academy of Neurology

2. Guideline summary
    a. Examination criteria
    b. Apnea testing
    c. Observation period
    d. Ancillary studies
    e. Algorithm for examination (Algorithm)
    f. Special populations
        i. Neonates
        ii. Teenage patients (PEDIATRIC TRAUMA PATIENTS)
3. Teaching materials
    a. PowerPoint slide set
    b. Neurologic examination
        i. Examination
        ii. How to perform oculocephalic (doll's eye) testing
        iii. How to perform oculovestibular (cold water caloric) testing
        iv. How to perform an apnea test (Apnea)
4. Documentation
    a. Checklist - downloadable form (From: Nakagawa et al. *Crit Care Med.* 2011;39(9):2139–2155)
    b. Sample notes formats:
        i. Note template in Word (Note_template)
        ii. Electronic medical record (EMR) version (EMR_sample)
5. Other materials
    a. Drug elimination table (Drug_elimination)
    b. Perfusion scan (Scan)

Tab 2: Guideline Summary

Examination criteria

- Appropriate patients for testing
  - Age >37 weeks gestational age to 18 years of age
  - Temperature >35°C
  - Normotensive without volume depletion
    - Blood pressure measured by indwelling arterial catheter is preferable.
    - Hypotension is defined as systolic blood pressure or mean arterial pressure <2 standard deviations below normal values for age norms.
  - Metabolic disturbances capable of causing coma should be identified and corrected.
  - Patient should have a known irreversible cause of coma. Drug intoxication, neurotoxins, and chemical exposures should be considered in cases where a cause of coma has not been identified.
  - Medications can interfere with the neurologic examination; sedatives, analgesics, antiepileptics, and neuromuscular blocking agents require adequate time for drug clearance (Drug elimination).
    - Stop all such medications and allow adequate time for drug metabolism.
    - Organ system dysfunction and hypothermia can alter drug metabolism.
    - Obtain blood or plasma levels to confirm drug levels are in the low to mid-therapeutic range.
    - If elevated levels are noted, an ancillary test can be performed.
  - Initial exam should be deferred for at least 24 hours after trauma or resuscitation event.
- Two examinations are performed by two different attending physicians.
- Observation period
  - Examinations are separated by an observation period.
    - Term newborns (>37 weeks gestational age) to 30 days: **24 hours**
    - Children >30 days to 18 years: **12 hours**
  - Reduction of the observation periods is acceptable using an accepted ancillary (Ancillary) study.
    - When an ancillary study is used to decrease the observation interval, two examinations and two apnea tests are recommended.
    - One examination (or all components that can be completed safely) and an apnea test should be completed before the ancillary study, and the second examination (or all components that can be completed safely) and an apnea test should be completed after the ancillary study.

The second examination can occur at any time following the ancillary study in children of all ages.

- Spinal reflexes may remain intact and do not preclude a determination of brain death.
- Presence of diabetes insipidus does not preclude a determination of brain death.
- Death is declared after the second neurologic examination and apnea test confirming an un-changed and irreversible condition.

Apnea testing (see Apnea test for detailed explanation)

- An apnea test should be performed with both exams. Both apnea tests may be performed by the same physician. The physician performing the apnea test should be trained in ventilator management.

  The arterial $PaCO_2$ should increase ≥20 mm Hg above baseline and reach at least 60 mm Hg, with the patient demonstrating no respiratory effort.

  If unable to perform safely or to complete the apnea test, an ancillary test should be performed.

Ancillary studies (for more detail, see (Ancillary)

- Ancillary testing is not required to make a determination of brain death.
- Ancillary testing is indicated in the following situations:

  Unable to safely perform or to complete apnea testing

  Unable to perform all components of the neurologic examination

  Uncertainty exists about the neurologic examination results

  A medication effect may be present that interferes with neurologic testing
- Ancillary testing may be used to reduce the intra-examination observation period.
- If ancillary tests are utilized, a second clinical examination of neurologic function and apnea testing should be performed.
- Accepted ancillary tests:

  Electroencephalogram (EEG) — ~30 minutes of monitoring is needed

  Radionuclide cerebral blood flow (“perfusion”) study
- Studies that have not been validated as ancillary tests:

  Transcranial Doppler sonography

  Computed tomography (CT) angiography

  Magnetic resonance imaging (MRI) angiography

Special populations

- Infants at 37 weeks estimated gestational age to 30 days of age

It is important to carefully and repeatedly examine term newborns with particular attention to examination of brainstem reflexes and apnea testing.

Assessment of neurologic function in the term newborn may be unreliable immediately after an acute catastrophic neurologic injury or cardiopulmonary arrest. A period of at least 24 hours is recommended before evaluating the term newborn for brain death.

The observation period between examinations should be 24 hours for term newborns (37 weeks) to 30 days of age.

Ancillary studies in newborns are less sensitive than in older children.

No data are available to determine brain death in infants < 37 weeks EGA.

- Teenage patients (?Older Pediatric Trauma Patients?)

Variability exists for the age designation of pediatric trauma patients. In some states, the age of the pediatric trauma patient is defined as <14 years of age.

If the pediatric trauma patient is cared for in the pediatric intensive care unit, the pediatric guidelines should be followed.

If the older pediatric trauma patient is cared for in an adult intensive care unit, the adult brain death guidelines should be followed.

Tab 3: Brain death determination

Educational media:

- PowerPoint slide set

Exam basics:

- Order of exam – There is no set order, but it is more efficient to test one ear for oculovestibular function at the beginning and the other at the end, so that the first ear tested has had time to warm back to body temperature.
- **Spontaneous movement –** NO spontaneous movement, even posturing, is seen in a brain-dead patient, though spinal reflexes may be present.
- **Response to pain**

  Method:

  Trapezius squeeze, supraorbital pressure, earlobe pinching, or sternal rub

  Observe for localization

  In brain death, there will be NO movement, excluding spinal cord events such as reflex withdrawal or spinal myoclonus.

  FYI --Do not be misled by testing for pain response on the foot as the patient may have an intact triple-flexion response, which is a spinal arc, and could be misinterpreted as localization.
- **Test cranial nerves**

  Corneal reflex

  Method:

  Hold the eyelid open

  Touch the cornea with gauze, tissue, or the tip of a swab

  Observe for eyelid (eyelash) movement

  Repeat on other eye

  In brain death, there will be NO movement.

  Tests cranial nerves V and VII

  Facial grimace

  Method:

  Apply a noxious stimulus to the face using supraorbital ridge pressure or a swab inserted into the nares with upward pressure against the turbinates.

  Observe face for grimace.

  In brain death, there will be NO grimace

  Tests cranial nerves V and VII

Pupillary response to light

In brain death, there is no response to light.

Pupils may be mid-position to dilated, but fixed.

Pupils need not be equal or dilated.

Tests cranial nerves II and III

Cough and gag

Stimulate the posterior pharynx

Suction the patient to depth of carina using an endotracheal suction catheter

Tests cranial nerves IX and X

Oculocephalic test (doll's eye reflex)

Contraindications

Presence of cervical collar

Physiology

Tests the extraocular muscle movements controlled by cranial nerves III and VI

Method

Hold the eyelids open.

The examiner moves the patient's head from side to side forcefully and quickly.

In brain death, the eyes always point in the direction of the nose and do not lag behind or move.

FYI

Even someone who is blind will have doll's eye reflex if the brainstem is intact.

The phenomena of the doll's eye reflex is based on old-fashioned dolls that had porcelain heads and wooden eyeballs. The wooden eyeballs would lag behind in movement when the porcelain head was turned due to inertia. Modern dolls (eg, Barbie) have eyes painted on the head.

A positive doll's eye reflex is normal; negative is indicative of brainstem dysfunction.

Oculovestibular test ("cold water calorics")

Note: this test may be substituted for occulocephalic testing in the patient with cervical spine injury.

- Contraindications
  - Ruptured tympanic membrane

        - Otorrhea
    - Materials needed:
        - Container of ice water
        - 20-60 mL syringe
        - IV tubing or 16- to 20-gauge IV catheter (needle removed)
        - Emesis basin and/or absorbent pad
    - Method:
        - Place absorbent pad under the patient's head.
        - Elevate the head of the bed to 30° so that the lateral semicircular canal is vertical.
        - Have someone hold the eyelids open so that the pupils can be observed.
        - Fill the syringe with ice water and attach the IV tubing or catheter.
        - Instill 40-60 mL of ice water into the external auditory meatus while observing for eye movement.
        - Allow at least a 5-minute interval before testing the other ear.
    - Interpretation
        - Any nystagmus is <u>not</u> consistent with brain death.
        - Physiology:
            - Ice water cools the endolymph in the semicircular canal.
            - Tests cranial nerves III, VI, and VIII
            - C-O-W-S: cold opposite, warm same. When cold fluid is instilled into the ear canal, the fast phase of nystagmus will be to the side opposite from the ear tested; in the comatose patient, the fast phase of nystagmus will be absent, as this is controlled by the cerebrum. Cold water instillation in the ear canal of a comatose patient will result in deviation of the eyes toward the ear being irrigated. When brainstem function is absent, no nystagmus will be observed.

- **Apnea test**

    Contraindications

        Patients with high cervical spine injury

        Patients requiring high levels of respiratory support

    Prior to the apnea test:

        Normalize $PaCO_2$; confirm with arterial blood gas measurements.

In a child with chronic lung disease, the child's baseline $PaCO_2$ should be used.

Confirm core temperature ≥35°C.

Normalize blood pressure.

Pre-oxygenate with 100% oxygen for 5-10 minutes.

Ensure correction of metabolic parameters and clearance of sedating pharmacologic agents. Ensure there is no recent use of neuromuscular blocking agents. Train-of- may be needed to confirm absence of neuromuscular blockade.

Performing the apnea test:

Methods of administering oxygen (FIO_2 = 1.0) while not ventilating patient:

T-piece connection providing O2.

Flow-inflating anesthesia bag with positive end-expiratory pressure titrated to the desired level.

Low-flow endotracheal tube insufflation with 100% O2. Caution: use of tracheal insufflation may be associated with CO2 washout and barotrauma and is not recommended in the pediatric guidelines.

Use of continuous positive airway pressure via the ventilator is not recommended as apnea may not be appreciated if the ventilator reverts to an assist mode when apnea is sensed

Monitor by direct visualization for any spontaneous respiratory effect

- In line end tidal CO2 monitoring can be used to measure any respiratory effort resulting in CO2 excursion

Arterial blood gas measures should be obtained every 3-5 minutes until apnea criteria are met (increase in $PaCO_2$ ≥20 mm Hg AND $PaCO_2$ ≥60 mm Hg).

Any spontaneous respiratory effort is NOT consistent with brain death.

FYI

In patients without significant pulmonary disease or injury, apneic oxygenation will permit the arterial oxygen saturation to remain high or change minimally. Despite no active ventilation, gas exchange continues to take place in the alveoli, with oxygen diffusing out of the alveoli and CO_2 diffusing into them. If the respiratory quotient is assumed to be 0.8, then for every 1 mL of oxygen consumed, 0.8 mL of CO_2 will be produced. As a result, there is a net entrainment of oxygen (the only gas being provided to the patient) down the tracheobronchial tree.

CO_2 rises ~4 mm Hg for every minute of apnea. The rate may be lower in the setting of brain death due to the loss of brain metabolism. At this rate, it will take at least 5 minutes of apnea for the pCO_2 to rise by 20 mm Hg; often it requires 7-9 minutes. Therefore, one may choose to draw a blood gas at minute 5-6 to of apnea, and continue the apnea observation while awaiting the results, so that another may be drawn every 2 - 3 minutes until the apnea criteria have been met.

Termination of apnea test:

Draw arterial blood gas to verify appropriate CO_2 change from baseline.

Place patient back on ventilator support.

Document test result.

Abort the apnea test and obtain ancillary testing if hemodynamic instability occurs or if unable to maintain SaO_2 ≥85%.

Ancillary testing

- Tests not required unless clinical examination or apnea test cannot be completed.
- Ancillary tests may not be used in lieu of clinical neurologic examination; rather, ancillary testing should be followed by a confirmatory clinical examination.
- Ancillary tests may be used to decrease the observation period. There is no specific recommendation on when the second clinical examination can be performed after the ancillary study to make a determination of death.
- If ancillary testing supports the diagnosis of brain death, then a second exam and apnea test should be performed, but repeat ancillary testing is not necessary.
- If the ancillary test is equivocal, then a 24-hour waiting period is recommended before retesting.
- Imaging studies such as CT or MRI scans are not considered ancillary studies to make a determination of brain death.
- Accepted ancillary studies

  Both EEG and cerebral blood flow have similar confirmatory value.

  Ancillary studies are less sensitive in newborns.

  "Gold standard" = four-vessel cerebral angiography

  Requires moving patient to angiography suite

  May be used in the presence of high-dose barbiturate therapy

  May be difficult to perform in smaller infants and children

  Cerebral blood flow study

  Commonly used with good experience in pediatric patients

May be used in the presence of high-dose barbiturate therapy

Standards established by Society of Nuclear Medicine and Molecular Imaging and the American College of Radiology

Example: no accumulation of tracer in non-perfused cranial vault, while scalp and facial structures are perfused

EEG

Standards established by American Electroencephalographic Society

Low to mid-therapeutic barbiturates levels should not preclude use of EEG

- Ancillary studies not yet validated and with little to no experience in children:

  Transcranial Doppler

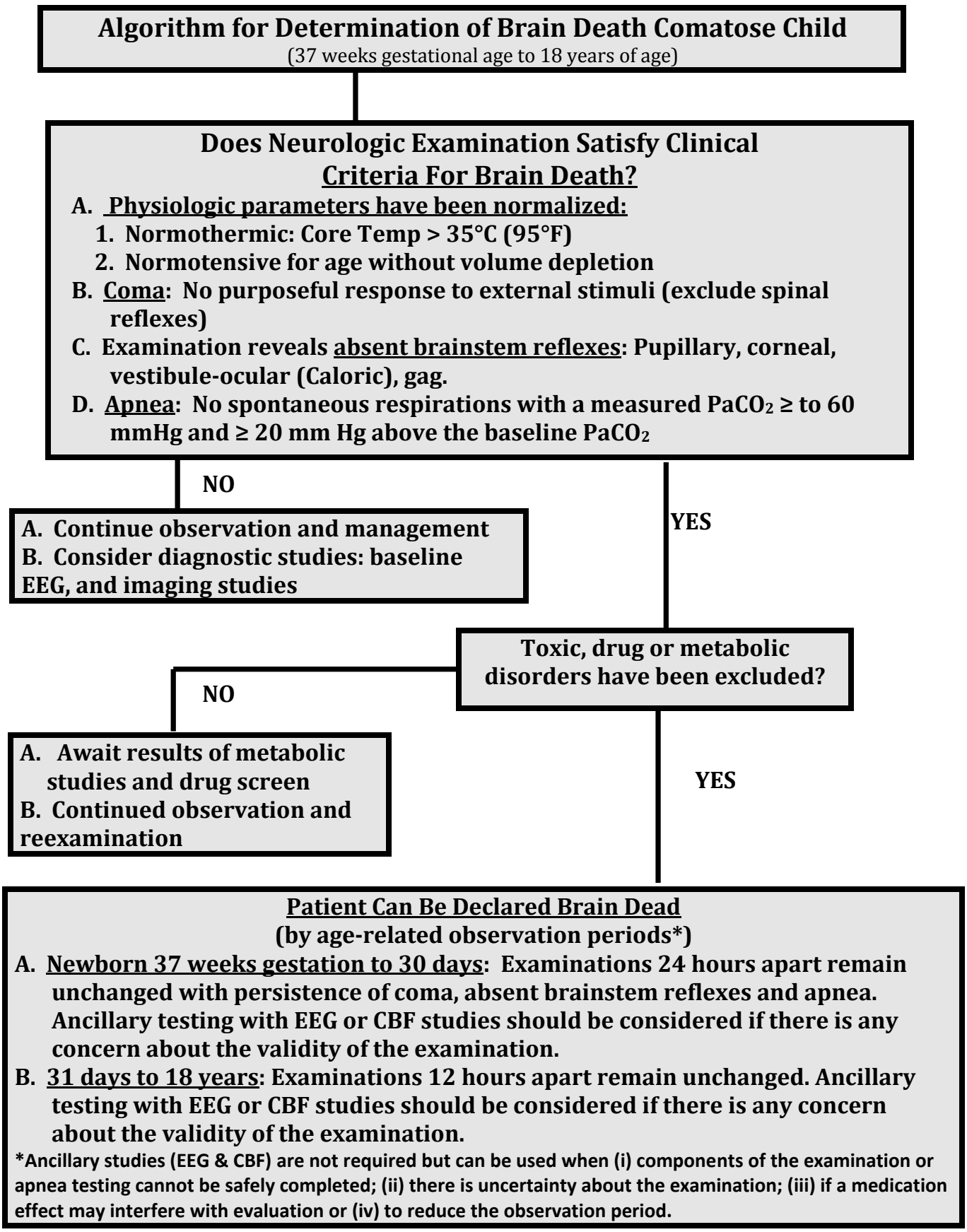
  CT angiography

  CT perfusion with spin labeling

  Nasopharyngeal somatosensory evoked potential studies

  MRI + magnetic resonance angiography

  Perfusion MRI


Algorithm for Determination of Brain Death Comatose Child
(37 weeks gestational age to 18 years of age)
Does Neurologic Examination Satisfy Clinical Criteria For Brain Death?
A. Physiologic parameters have been normalized:
1. Normothermic: Core Temp > 35°C (95°F)
2. Normotensive for age without volume depletion
B. Coma: No purposeful response to external stimuli (exclude spinal reflexes)
C. Examination reveals absent brainstem reflexes: Pupillary, corneal, vestibule-ocular (Caloric), gag.
D. Apnea: No spontaneous respirations with a measured PaCO2 ≥ to 60 mmHg and ≥ 20 mm Hg above the baseline PaCO2
NO
YES
A. Continue observation and management
B. Consider diagnostic studies: baseline EEG, and imaging studies
Toxic, drug or metabolic disorders have been excluded?
NO
YES
A. Await results of metabolic studies and drug screen
B. Continued observation and reexamination
Patient Can Be Declared Brain Dead
(by age-related observation periods*)
A. Newborn 37 weeks gestation to 30 days: Examinations 24 hours apart remain unchanged with persistence of coma, absent brainstem reflexes and apnea. Ancillary testing with EEG or CBF studies should be considered if there is any concern about the validity of the examination.
B. 31 days to 18 years: Examinations 12 hours apart remain unchanged. Ancillary testing with EEG or CBF studies should be considered if there is any concern about the validity of the examination.
*Ancillary studies (EEG & CBF) are not required but can be used when (i) components of the examination or apnea testing cannot be safely completed; (ii) there is uncertainty about the examination; (iii) if a medication effect may interfere with evaluation or (iv) to reduce the observation period.

Brain Death Examination for Infants and Children

Two physicians must perform independent examinations separated by specified intervals

Age of Patient	Timing of first examination	Examination interval
☐ Term newborn (≥37 weeks gestational age) and up to 30 days old	☐ First exam may be performed 24 hours after birth OR 24 hours following cardiopulmonary resuscitation or other severe brain injury	☐ At least 24 hours ☐ Interval shortened because ancillary study (section 4) is consistent with brain death
☐ 31 days to 18 years old	☐ First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury	☐ At least 12 hours OR ☐ Interval shortened because ancillary study (section 4) is consistent with brain death

Section 1. PREREQUISITES for brain death examination and apnea test

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)

☐ Traumatic brain injury ☐ Anoxic brain injury ☐ Known metabolic disorder ☐ Other (Specify) _____

B. Correction of contributing factors that can interfere with the neurologic examination	**Examination One**		**Examination Two**	
a. Core Body Temp is ≥95°F (≥35°C)	☐ Yes	☐ No	☐ Yes	☐ No
b. BP_S or MAP in acceptable range for age (BP_S should not be less than 2 standard deviations below age appropriate norm)	☐ Yes	☐ No	☐ Yes	☐ No
c. Sedative/analgesic drug effect excluded as a contributing factor*	☐ Yes	☐ No	☐ Yes	☐ No
d. Metabolic intoxication excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
e. Neuromuscular blockade excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No

If ALL prerequisites are marked YES, then proceed to section 2; if not, then defer examination. *See Section 4.

Section 2. PHYSICAL EXAMINATION *NOTE: Spinal cord reflexes are acceptable*	**Examination One Date/ time:** _____		**Examination Two Date/ Time:** _____	
a. Flaccid tone, patient unresponsive to deep painful stimuli	☐ Yes	☐ No	☐ Yes	☐ No
b. Pupils are midposition or fully dilated; light reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
c. Corneal, cough, gag reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
Sucking and rooting reflexes are absent (in neonates and infants)	☐ Yes	☐ No	☐ Yes	☐ No
d. Oculovestibular reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
e. Spontaneous respiratory effort while on mechanical ventilation is absent	☐ Yes	☐ No	☐ Yes	☐ No

Explain any exam element that could not be performed: _____

Section 3. APNEA TEST	**Examination One Date/ time:** _____	**Examination Two Date/ Time:** _____
☐ Exam 1: No spontaneous respiratory efforts were observed despite final $PaCO_2$ ≥ 60 mm Hg and a ≥ 20 mm Hg increase above baseline. ☐ Exam 2: No spontaneous respiratory efforts were observed despite final $PaCO_2$ ≥ 60 mm Hg and a ≥ 20 mm Hg increase above baseline.	Pre $PaCO_2$: _____ Apnea duration: _____ minutes Post $PaCO_2$: _____	Pre $PaCO_2$: _____ Apnea duration: _____ minutes Post $PaCO_2$: _____

Apnea test is contraindicated or could not be completed due to: _____ _____. *Ancillary study (EEG or radionuclide CBF) was performed. (See Section 4)*

Section 4. ANCILLARY TESTING is required when: (1) components of the examination or apnea testing cannot be completed; (2) if there is uncertainty about the results of the neurologic examination; or (3) if a medication effect may be present. **Ancillary testing may be performed to reduce the inter-examination period however a second neurologic examination is required.**	**Date/Time:** _____
☐ Electroencephalogram (EEG) report documents electrocerebral silence ***OR*** ☐ Cerebral Blood Flow (CBF) study report documents no cerebral perfusion	☐ Yes ☐ No ☐ Yes ☐ No

Section 5. SIGNATURES

Examiner One
I certify that my examination is consistent with cessation of function of the brain and brainstem. Confirmatory exam to follow.

_____ _____
(Printed Name) (Signature)

_____ _____ _____ _____
(Specialty) (Pager/ID #) (Date) (Time)

Examiner Two
I certify that my examination and/or ancillary test report confirms unchanged and irreversible cessation of function of the brain and brainstem.
Date/Time of death: _____

_____ _____
(Printed Name) (Signature)

_____ _____ _____ _____
(Specialty) (Pager/ID #) (Date) (Time)

From Nakagawa TA, Ashwal S, Mathur M, et al. Guidelines for the determination of brain death in infants and children: an update of the 1987 task force recommendations. Crit Care Med. 2011; 39(9):2139-2155.

Medications Administered to Critically Ill Pediatric Patients and Recommendations for Time Interval after Discontinuation until Testing

Medication	Infants/Children Elimination Half-Life	Neonates Elimination Half-Life
Intravenous induction, anesthetic, and sedative agents		
Thiopental	Adults: 3–11.5 hrs (shorter half-life in children)	
Ketamine	2.5 hrs	
Etomidate	2.6–3.5 hrs	
Midazolam	2.9–4.5 hrs	4–12 hrs (77–80)
Propofol	2–8 mins, terminal half-life 200 mins (range, 300–700 mins)	
Dexmedetomidine	Terminal half-life 83–159 mins (79–81)	Infants have faster clearance (81–83)
Antiepileptic drugs		
Phenobarbital	Infants: 20–133 hrs[a]; children: 37–73 hrs[a]	45–500 hrs[a] (79, 84, 85)
Pentobarbital	25 hrs[a]	
Phenytoin	11–55 hrs[a]	63–88 hrs[a]
Diazepam	1 month to 2 yrs: 40–50 hrs 2–12 yrs: 15–21 hrs 12–16 yrs: 18–20 hrs	50–95 hrs (79, 86, 87)
Lorazepam	Infants: 40.2 hrs (range, 18–73 hrs) Children: 10.5 hrs (range, 6–17 hrs)	40 hrs (88)
Clonazepam	22–33 hrs	
Valproic acid	Children >2 months: 7–13 hrs[a] Children 2–14 yrs: mean 9 hrs; range, 3.5–20 hrs	10–67 hrs[a]
Levetiracetam	Children 4–12 yrs: 5 hrs	
Intravenous narcotics		
Morphine sulfate	Infants 1–3 months: 6.2 hrs (5–10 hrs) 6 months to 2.5 yrs: 2.9 hrs (1.4–7.8 hrs) Children: 1–2 hrs	7.6 hrs (range, 4.5–13.3 hrs) (79, 89–91)
Meperidine	Infants <3 months: 8.2–10.7 hrs (range, 4.9–31.7 hrs); infants 3–18 months: 2.3 hrs Children 5–8 yrs: 3 hrs	23 hrs (range, 12–39 hrs)
Fentanyl	5 months to 4.5 yrs: 2.4 hrs (mean); 0.5–14 yrs: 21 hrs (range, 11–36 hrs for long-term infusions)	1–15 hrs
Sufentanil	Children 2–8 yrs: 97 ± 42 mins	382–1,162 mins
Muscle relaxants		
Succinylcholine	5–10 mins; prolonged duration of action in patients with pseudocholinesterase deficiency or mutation	
Pancuronium	110 mins	
Vecuronium	41 mins	65 mins
Atracurium	17 mins	20 mins
Rocuronium	3–12 months: 1.3 ± 0.5 hrs 1 to <3 yrs: 1.1 ± 0.7 hrs 3 to <8 yrs: 0.8 ± 0.3 hrs Adults: 1.4–2.4 hrs	

[a]Elimination half-life does not guarantee therapeutic drug levels for longer-acting medications or medications with active metabolites. Drug levels should be obtained to ensure that levels are in a low to midtherapeutic range before neurologic examination to determine brain death. In some instances, this may require waiting several half-lives and rechecking serum levels of the medication before conducting the brain death examination.

Modified from Ashwal and Schneider (57). Metabolism of pharmacologic agents may be affected by organ dysfunction and hypothermia. Physicians should be aware of total amounts of administered medication that can affect drug metabolism and levels.

From Nakagawa TA, Ashwal S, Mathur M, et al. Guidelines for the determination of brain death in infants and children: an update of the 1987 task force recommendations. Crit Care Med. 2011; 39(9):2139-2155.

Example of Electronic Medical Record Documentation for
Determination of Pediatric Brain Death

Pediatric Brain Death Examination Documentation 12/10/2014 7:27 PM

{EXAM SEQUENCE:30431189}

Note: For use with patients 37 weeks gestation to 18 years of age. The patient must be examined in this hospital during treatment of potentially correctable abnormalities. Determination of brain death in infants and children must be made by two attending physicians. The examining physicians will initiate each applicable component of the exam and where appropriate, document supporting laboratory or examination data. **All boxes must be completed**

Have reasonable efforts been made to notify the patient's parents/legal guardian that a determination of brain death will soon be completed? {YES (DEF)/NO:23119}

Age of Patient	Timing of First Exam	Inter-exam Interval
Term newborn, 37 weeks gestational age up to 30 days	First exam may be performed 24 hrs after birth OR following cardiopulmonary resuscitation or other severe brain injury	☐ At least 24 hours ☐ Interval shortened due to ancillary study consistent with brain death
31 days of age to 18 years	First exam may be performed 24 hrs following cardiopulmonary resuscitation or other severe brain injury	☐ At least 12 hours ☐ Interval shortened due to ancillary study consistent with brain death

Definition of Hypotension

Age	Systolic Blood Pressure (mmHg)
Neonates >37 weeks (0-28 days)	< 60
Infants 1-12 months	< 70
Children 1-10 years	< 70 + (2 x age in years)
Children > 10 years	< 90

I. PREREQUISITES for Brain Death Examination

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma: {WH PED CAUSE OF COMA:30431190}	
B. Correction of contributing factors that can interfere with neuro exam:	**Exam**
1) Core Body temp > 95°F (35° C) for a minimum of 24 hours, preferably longer.	☐ Yes ☐ No
2) Systolic blood pressure or MAP in acceptable range based on age Systolic BP should not be > 2 standard deviations below age appropriate Norm) NOTE: Vasopressor agents may be used to support arterial blood pressure	☐ Yes ☐ No
3) Sedative/analgesic drug effect excluded as a contributing factor (Anticonvulsants within normal therapeutic ranges are acceptable)	☐ Yes ☐ No
4) Metabolic intoxication excluded as a contributing factor	☐ Yes ☐ No
5) Neuromuscular blockade excluded as a contributing factor	☐ Yes ☐ No

If ALL prerequisites are marked YES, then proceed to Section II (Physical Exam), or if confounding variable(s) present, proceed to Section IV (Ancillary Study):

ALL prerequisites are marked YES:

II. Physical Exam (Please check) **NOTE: Spinal Cord Reflexes are acceptable**	**Exam Date/Time:** 12/10/2014 7:33 PM
A) Flaccid tone, patient unresponsive to deep painful stimuli	☐ Yes ☐ No
B) Pupils are midposition or fully dilated and light reflexes are absent	☐ Yes ☐ No
C) Corneal, cough, gag reflexes are absent. In neonates and infants, sucking and rooting reflexes are absent	☐ Yes ☐ No
D) Oculovestibular reflexes are absent	☐ Yes ☐ No
E) Spontaneous respiratory effort is absent	☐ Yes ☐ No

If all elements of the Physical Exam are complete, proceed to Section III (Apnea Test). If an element of the Physical Exam cannot be performed, proceed to Section IV (Ancillary Study).

III. APNEA Test - May be performed by same physician for both exams - Preoxygenate patient with 100% oxygen for 5 minutes. Once Preoxygenated, change mechanical ventilation to continuous positive pressure Ventilation or a Mapleson circuit while observing for any spontaneous Respiratory movements. PaCO2 must be allowed to rise to ≥ 60 torr and > 20 torr over baseline PaCO2. If no respiratory effort is noted at PaCO2 >60 Torr and > 20 torr above baseline, documentation of apnea consistent with Neurologic death is noted. The patient is placed back on mechanical Ventilation until death is confirmed with a repeat clinical examination or Ancillary testing.	**Exam Date/Time** 12/10/2014 7:34 PM
☐ No spontaneous respiratory efforts were observed despite final PaCO2 ≥ 60 mmHg and a ≥ 20 mmHg increase above baseline	**Pretest PaCO2:** {N/A OR FT:27688} **Apnea duration:** {N/A OR FT:27688} min **Post-test PaCO2:** {N/A OR FT:27688}
- or -	
☐ Apnea test is contraindicated or could not be performed to Completion because of: {WH PED DNC APNEA EXCLUSION:30431191}. Ancillary study was therefore performed to document brain death (Section IV)	

Ancillary test performed to document brain death:

IV. ANCILLARY testing is required when any of the components of the exam or apnea test cannot be completed; if there is uncertainty about the results of the neurologic exam; or, if a medication effect may be present. Ancillary testing can be performed to reduce the inter-examination period; however, a second neurologic exam is required. Components of the neurologic exam that can be performed safely should be completed in close proximity to the ancillary test.	**Date/Time:** 12/10/2014 7:34 PM
☐ Electroencephalogram (EEG) report documents electrocerebral silence	☐ Yes ☐ No
- or-	
☐ Cerebral Blood Flow (CBF) study report documents no cerebral perfusion	☐ Yes ☐ No

Pend Share Sign Cancel

Electronic Medical Record Sample Note

(Information in "{ }" are included as drop down lists for selection; see next page for list contents.

**** used to allow for free text entry)*

Neurological Function Exam - {PICU INITIAL/CONFIRMATORY}

The irreversible and identifiable cause of coma include: {PICU CAUSE OF COMA}.

The following criteria have been evaluated:

Core Body Temp > 35 degrees Celsius: {YES/NO}
Systolic BP or MAP in acceptable range: {YES/NO}
Sedative/analgesic drug effect excluded as a contributing factor: {YES/NO}
Phenobarbital: {PICU PHENOBARBITOL}
Pentobarbital: {PICU PENTOBARBITAL}
Metabolic intoxication excluded as a contributing factor: {YES/NO}
Neuromuscular blockers excluded as a contributing factor: {YES/NO}

Exam:

Cortical Function:

	Yes	No
Spontaneous movement is absent		
Response to voice is absent		
Facial grimace in response to painful stimuli is absent		

Brainstem Function:

	Yes	No
Pupils are midpostion or fully dilated and light reflexes are absent		
Corneal, cough, gag reflexes are absent		
Sucking and rooting reflexes are absent (in neonates and infants)		

Oculo-vestibular response: {OCULO-VESTIBULAR RESPONSE}.
Oculocephalic response (Doll's Eye): {PICU OCULOCEPHALIC RESPONSE}.
Respiratory drive: {PICU RESPIRATORY DRIVE}.

Ancillary Tests (not required in any age group, but may decrease exam interval): {PICU ANCILLARY TEST}.

This exam demonstrates irreversible cessation of all activity in the cerebral hemispheres and brainstem. {PICU NEURO EXAM DISPOSITION}.

Signature_____ Date/Time _____

EMR choice descriptor	**Choices** (more than one response can be selected in some categories; *** indicates ability to enter free text)
{PICU INITIAL/CONFIRMATORY}	• Initial • Confirmatory
{PICU CAUSE OF COMA}	• Traumatic brain injury • Anoxic brain injury • Known metabolic disorder • ***
{PICU PHENOBARBITOL}	• Not used in this patient • Level = *** at *** • ***
{PICU PENTOBARBITAL}	• Not used in this patient • Level = *** at *** • ***
{OCULO-VESTIBULAR RESPONSE}	• Absent • Absent left (unable to test right) • Absent right (unable to test left) • Unable to test due to CSF leak • ***
{PICU OCULOCEPHALIC RESPONSE}	• No response (negative) • N/A - unable to perform secondary to spine immobilization or facial injuries • ***
{PICU RESPIRATORY DRIVE}.	• Not yet performed • N/A - unable to test secondary to concurrent cardiopulmonary dysfunction • Absent as evidenced by an apnea test. Pretest pCO2 was ***. Patient was pre-oxygenated with FiO2 = 1.0 for several minutes. Patient was then placed on CPAP (no breaths) via ETT. After *** minutes, a blood gas was drawn. Pulse oximetry and hemodynamics were stable throughout. Blood gas result: pH ***, pCO2 ***, pO2 ***, indicating a pCO2 increase of *** mm Hg • Apnea test being performed by another physician, see additional note
{PICU ANCILLARY TEST}	• Not indicated at this time • EEG: {PICU EEG} • Cerebral Perfusion Study: {PICU CEREBRAL PERFUSION STUDY}
{PICU EEG}	• Ordered • In progress • Pending reading • Electrocerebral silence • ***
{PICU CEREBRAL PERFUSION STUDY}	• Ordered • Absent cerebral blood flow • ***
{PICU NEURO EXAM DISPOSITION}	• A confirmatory exam will be performed in approximately 24 hours by a second physician, given the child's age is less than 31 days • A confirmatory exam will be performed in approximately 12 hours by a second physician, given the child's age is greater than or equal to 31 days • An ancillary test is planned, a confirmatory test will be performed in *** hours • Results discussed with family. • Time of death ***

Electronic Medical Record Sample Note: MS Word Format

*("{ " are included as drop down lists for selection. *** allow for free text entry)*

Neurological Function Exam - PICU { **INITIAL** / **CONFIRMATORY**

Name: Admission Date:

Hospital #: MRN: Attending Provider:

Room/Bed: DOB: Age:

The irreversible and identifiable cause of coma include:

{ Traumatic brain injury / Anoxic brain injury / Known metabolic disorder / *** }

The following criteria have been evaluated:

Core Body Temp >35°C:

{ Yes / No }

Systolic BP or MAP in acceptable range:

{ Yes / No }

Sedative/analgesic drug effect excluded as a contributing factor:

{ Yes / No }

Phenobarbital:

{ Not used in this patient / Level *** at *** }

Pentobarbital:

{ Not used in this patient / Level *** at *** }

Metabolic intoxication excluded as a contributing factor:

{ Yes / No }

Neuromuscular blockers excluded as a contributing factor:

{ Yes / No }

Exam:

Cortical Function:

	Yes	No
Spontaneous movement is absent		
Response to voice is absent		
Facial grimace in response to painful stimuli is absent		

Brainstem Function:

	Yes	No
Pupils are midposition or fully dilated and light reflexes are absent		
Corneal, cough, gag reflexes are absent		
Sucking and rooting reflexes are absent (in neonates and infants)		

Oculovestibular response:

- Absent
- Absent left (unable to test right)
- Absent right (unable to test left)
- Unable to test due to CSF leak
- ***

Oculocephalic response (doll's eye):

- No response (negative)
- N/A - unable to perform secondary to spine immobilization or facial injuries
- ***

Respiratory drive:

- Not yet performed
- N/A unable to test secondary to concurrent cardiopulmonary dysfunction
- Absent as evidenced by an apnea test. Pretest pCO_2 was ***. Patient was pre-oxygenated with FIO_2 = 1.0 for several minutes. Patient was then placed on CPAP (no breaths) via ETT. After *** minutes, a blood gas was drawn. Pulse oximetry and hemodynamics were stable throughout. Blood gas result: pH ***, pCO^2 ***, pO_2 ***, indicating a pCO_2 increase of *** mm Hg

Apnea test being performed by another physician, see additional note
***

Ancillary Tests (not required in any age group, but may decrease exam interval):

- Not indicated at this time
- EEG:
  - Ordered
  - In progress
  - Pending reading
  - Electrocerebral silence
  - ***
- Cerebral Perfusion Study:
  - Ordered
  - Absent cerebral blood flow
  - ***

This exam demonstrates irreversible cessation of all activity in the cerebral hemispheres and brainstem.

- A confirmatory exam will be performed in approximately 24 hours by a second physician; given the child's age is less than 31 days
- A confirmatory exam will be performed in approximately 12 hours by a second physician, given the child's age is 31 days or greater
- An ancillary test is planned
- A confirmatory test will be performed in *** hours
- Results discussed with family.
- Time of death ***
- ***

Attending performing exam:

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BRAIN DEATH

Jana Stockwell, MD, FCCM

2014

DEFINITION

- Circulatory death:
  - Cessation of cardiac activity
- Brain death: Irreversible cessation of all functions of the entire brain, including the brain stem

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HISTORY

- First introduced in a 1968 report authored by a special committee of the Harvard Medical School
- Adopted in 1980, with modifications, by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research, as a recommendation for state legislatures and courts
- The "brain death" standard was employed in the legislation known as the Uniform Determination of Death Act, which has been enacted by a large number of jurisdictions and the standard has been endorsed by the American Bar Association.
- In 1987, the 1st pediatric guidelines were published
- Revised in 2011 for children 37 weeks to 18 years

PEDIATRIC GUIDELINES

- **Guidelines for the determination of brain death in infants and children: an update of the 1987 task force recommendations.** *Crit Care Med*. 2011;39(9):2139–2155. Nakagawa *et al*.
- Endorsed by:
  - Society of Critical Care Medicine
  - Section on Critical Care, AAP
  - Section on Neurology, AAP
  - Child Neurology Society
  - Many others

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REVISED PEDIATRIC GUIDELINES

- American College of Critical Care Medicine formed a multidisciplinary committee
- Goal: review the neonatal and pediatric literature from 1987 & update recommendations
- Evidence weighed using Grading of Recommendations Assessment, Development and Evaluation (GRADE) classification system

ANATOMY OF HUMAN BRAIN – 3 REGIONS

- Cerebrum
  - Controls memory, consciousness, and higher mental functioning
- Cerebellum
  - Controls various muscle functions
- Brain stem consisting of the midbrain, pons, and medulla, which extends downwards to become the spinal cord
  - Controls respiration and various basic reflexes (e.g., swallow and gag)

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COMA

- Deep coma
  - Non-responsive to most external stimuli
  - Have a dysfunctional cerebrum but, by virtue of the brain stem remaining intact, are capable of spontaneous breathing and heartbeat
- PVS – persistent vegetative state
  - Eyes may move
  - May have sleep-wake cycles

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RELATIONSHIP OF ORGAN FUNCTION

- Heart
  - Needs O_2 to survive and without O_2 will stop beating
  - Not controlled by the brain but it is autonomous
- Breathing
  - Controlled by vagus nerve, located in the brain stem
  - Main stimulant for vagus nerve is ↑ CO_2 in the blood
    - Causes the diaphragm & chest muscles to expand
    - Spontaneous breathing can not occur after brain stem death
- With artificial ventilation, the heart may continue to beat for a period of time after brain stem death
- Time lag between brain death and circulatory death in the unsupported patient is generally ~2-10 days, but much longer in those with fully supported organ function.

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REVISIONS TO CRITERIA

	1987	2011
Waiting period before initial brain death examination	Not specified	24 hrs after CPR or severe acute brain injury is suggested
Core body temp	Not specified	35°C (95°F)
# of clinical exams	2; 1 if ancillary testing confirms in 2 mos-1 year age group	2, even if ancillary testing done
# of examiners	Not specified	2 different attendings
Observation interval	7d-2m: 48 hrs 2m-12m: 24 hrs >1yr: 12 hrs, 24 if HIE	37 weeks-30d: 24 hrs 31d-18yr: 12 hrs
Decreased observation time	In age >1yr, if cerebral blood flow or EEG consistent with dx	Permitted in either age group if cerebral blood flow or EEG consistent with dx

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REVISIONS TO CRITERIA

	1987	2011
Apnea testing	Required, but not specified how many	2 required unless clinically contraindicated
Final pCO_2 threshold	Not specified	≥60 mmHg & ≥20 mmHg above baseline
Ancillary study	7d-2m: 2 EEGs separated by 48hrs 2m-1y: 2 EEGs separated by 24h, or a cerebral blood flow study instead of 2nd >1y: none	Required only if unable to complete exam and apnea test
Time of death	Not specified	Time of 2nd exam & apnea test or ancillary study

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INITIAL REQUIREMENTS

- Clinical or radiographic evidence of an acute catastrophic cerebral event consistent w/ dx of brain death
- Exclusion of conditions that confound clinical evidence (i.e.-metabolic)
- Confirmation of absence of drug intoxication or poisoning
  - Barbiturates, NMB's, etc.
- Core body temp >35°C

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BASIC EXAM
PAIN

- Cerebral motor response to pain
  - Supraorbital ridge, the nail beds, trapezius
  - Motor responses may occur spontaneously during apnea testing (spinal reflexes)
  - Spinal reflex responses occur more often in young
  - If patient had paralytic, then test w/ train-of-four
- Spinal arcs are intact!
  - Triple flexion response of legs

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BASIC EXAM
PUPILS

- Round, oval, or irregularly shaped
- Midsize (3-6 mm), but may be totally dilated
- Absent pupillary light reflex
  - Although drugs can influence pupillary size, the light reflex remains intact only in the absence of brain death
  - IV atropine does not markedly affect reactivity, but does affect size
  - Topical administration of drugs and eye trauma may influence pupillary size and reactivity
  - Pre-existing ocular anatomic abnormalities may also confound pupillary assessment in brain death
  - Paralytics do not affect pupillary size or response
  - Dilated pupils suggest anticholinergic drugs (TCAs, neuroleptics) or sympathomimetic drugs (cocaine, amphetamines, theophylline)

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BASIC EXAM
EYE MOVEMENT

- Oculocephalic reflex = doll's eyes
  - Not based on Barbie type dolls with painted eyes
  - But on old fashioned type dolls with wooden eyes in porcelain heads

- Vestibulo-ocular = cold caloric test

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DOLL'S EYES

- Contraindication
  - Presence of cervical collar – oculovestibular testing ("cold calorics") may still be done
- Physiology
  - Tests the extraocular muscle movements controlled by cranial nerves III and VI
- Method
  - Hold the eyelids open
  - Examiner moves the patient's head from side to side forcefully and quickly

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OCULOCEPHALIC REFLEX

- In brain death, the eyes always point in the direction of the nose and do not lag behind or move

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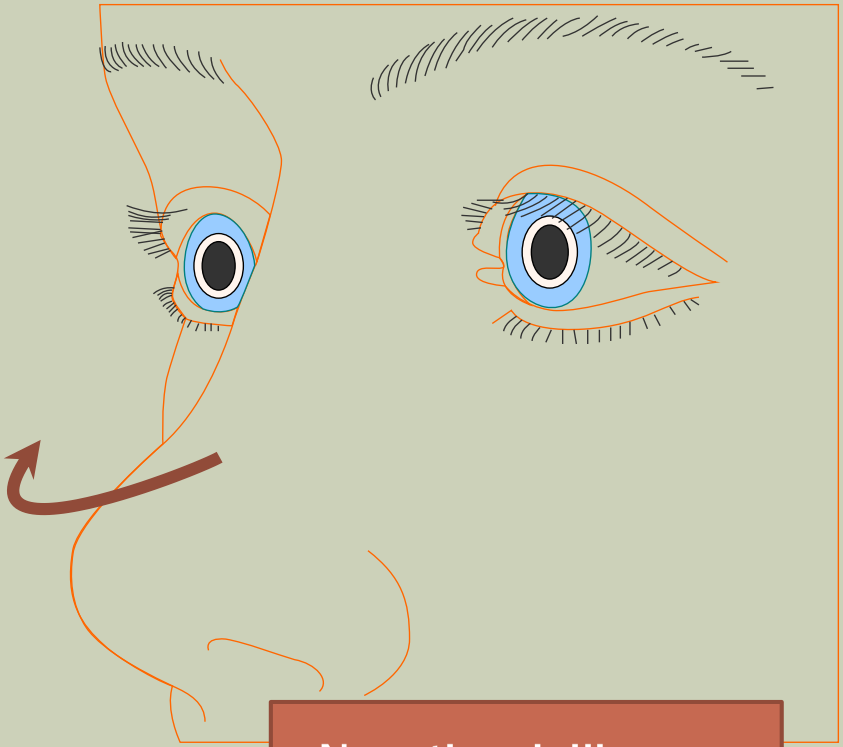
FYI

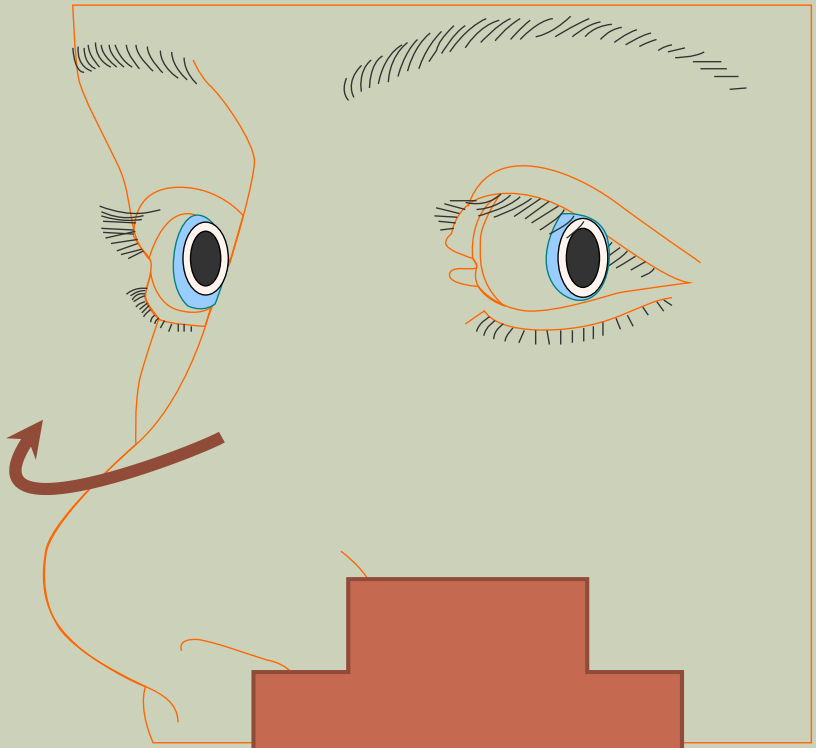
Even someone who is blind will have doll's eye reflex if the brainstem is intact

Example: Head turned abruptly to right



Negative doll's eyes

-- Eyes continue to point straight forward despite head turn
-- Equates to brainstem dysfunction



Positive doll's eyes

-- You have them!

OCULOVESTIBULAR: COLD CALORICS

- Contraindication:
  - Ruptured tympanic membrane
  - Otorrhea
- Method:
  - Elevate the HOB 30° to properly orient the semi-circular canal
  - Irrigate tympanic membrane with 40-60 mL iced water. Do 1 ear at beginning of exam and 1 at end to allow endolymph temp to equilibrate
  - Observe patient for 1 minute after each ear irrigation, with a 5 minute wait between testing of each ear

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OCULOVESTIBULAR: COLD CALORICS

- Ice water cools the endolymph in the semicircular canal
- Tests cranial nerves III, VI, and VIII
- C-O-W-S: cold opposite, warm same. When cold fluid is instilled into the ear canal, the fast phase of nystagmus will be to the side opposite from the ear tested
  - In the comatose patient, the fast phase of nystagmus will be absent, as this is controlled by the cerebrum. Cold water instillation in the ear canal of a comatose patient will result in tonic deviation of the eyes toward the ear being irrigated.
  - In the brain dead patient, no nystagmus will be observed

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COLD CALORICS INTERPRETATION

- Movement only of eye on side of stimulus
  - Internuclear ophthalmoplegia
  - Suggests brainstem structural lesion
- Tonic deviation of both eyes
  - Coma
- No eye movement
  - Brainstem injury / brain death
  - Facial trauma involving the auditory canal and petrous bone can also inhibit these reflexes

FACIAL SENSORY & MOTOR RESPONSES

- Corneal reflexes are absent in brain death
  - Corneal reflexes - tested by using a cotton-tipped swab
  - Grimacing in response to pain can be tested by applying deep pressure to the nail beds, supraorbital ridge, TMJ, or swab in nose
  - Severe facial trauma can inhibit interpretation of facial brain stem reflexes

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PHARYNGEAL AND TRACHEAL REFLEXES

- Both gag and cough reflexes are absent in patients with brain death
  - Gag reflex can be evaluated by stimulating the posterior pharynx with a tongue blade, but the results can be difficult to evaluate in orally intubated patients
  - Cough reflex can be tested by using suction catheter deep, past end of endotracheal tube

APNEA TESTING

- Contraindications:
  - Patients with high cervical spine injury
  - Patients requiring high levels of respiratory support
- Goal:
  - $paCO_2$ levels ≥ 60 mmHg
  - ≥20 mmHg over baseline
    - In a child with chronic lung disease, the child's baseline $PaCO_2$ should be used

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APNEA TESTING TECHNIQUE

- Pre-oxygenate with 100% oxygen several minutes
- Allow baseline $PaCO_2$ to be ~40 mmHg
- Place patient on T-piece or flow inflating bag
  - Titration of PEEP via a flow inflating bag may assist in preventing alveolar collapse and derecruitment
  - Use of CPAP via the ventilator is not recommended as apnea may not be appreciated if the ventilator reverts to an assist mode when apnea is sensed
- Observe for respiratory effort for ~6-10 minutes

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APNEA TESTING

- CO_2 rises ~4 mm Hg every minute of apnea
  - The rate may be lower in the setting of brain death due to the loss of brain metabolism
- At this rate, it will take at least 5 minutes of apnea for the pCO_2 to rise by 20 mm Hg; often it requires 7-9 minutes
- Therefore, one may choose to draw an arterial blood gas at minute 5-6 of apnea, and continue the apnea observation while awaiting the results. Repeat gas every 2 minutes until the apnea criteria have been met or the test must be aborted.
- Abort testing if the SpO_2 falls below 85% or there is hemodynamic instability

619

APNEIC OXYGENATION

- In patients without significant pulmonary disease or injury, apneic oxygenation will permit the arterial oxygen saturation to remain high or change minimally.
- Despite no active ventilation, gas exchange continues to take place in the alveoli, with oxygen diffusing out of the alveoli and CO_2 diffusing into them.

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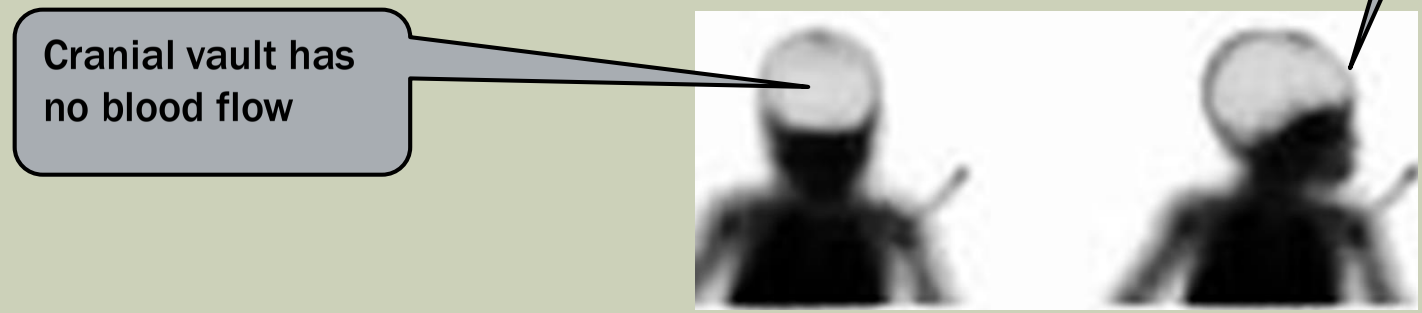
APNEIC OXYGENATION

- If the respiratory quotient is assumed to be 0.8, then for every 1 mL of oxygen consumed, 0.8 mL of CO_2 will be produced.
- As a result, there is a net entrainment of oxygen (the only gas being provided to the patient) down the tracheobronchial tree.

621

CONFIRMATORY TESTING

- Gold standard: 4 vessel angiography
  - Rarely done
- Cerebral blood flow = perfusion scan



- EEG
  - Standards established by American Electroencephalographic Society
  - Low to mid-therapeutic barbiturates levels should not preclude use of EEG

APPROPRIATE TERMINOLOGY

- Say “dead”, not “brain dead”
- Say “artificial or mechanical ventilation”, not “life support”
- Time of death = time of second examination, including apnea and/or ancillary test completion. When a patient meets all criteria for brain death, they are legally dead.
  - NOT when ventilator removed
  - NOT when heart beat ceases
- State law and local institutional policies should be reviewed and followed.
- Ask staff not talk to the patient as if he’s still alive

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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor,
Plaintiff,

Plaintiffs,

v.

Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive,

Defendants.

Case No: 2:16-cv-00889-KJM-EFB

PETITION AND ORDER FOR APPOINTMENT OF GUARDIAN AD LITEM

/ / /

/ / /

Petitioner states as follows:

1. Petitioner is the mother of Israel Stinson.

2. Petitioner seeks to be appointed as the guardian ad litem in this matter. The Petitioner who seeks the appointment is:

Jonee Fonseca
[redacted]
Rancho Cordova CA 95670

3. The guardian ad litem is to represent the interests of:

Israel Stinson, who resides with the Petitioner.

4. Israel Stinson is an infant who was born on [redacted], 2013.

5. There has been no previous petition for appointment of a guardian ad litem filed in this matter.

6. The appointment of a guardian ad litem is necessary because Israel Stinson is an infant who has neither the capacity to sue on his own behalf, nor the ability to speak on his own behalf.

7. The complaint in this matter involves Petitioner's attempt to save Israel's life, as he is currently hospitalized and the hospital seeks to immediately remove life support for him

8. The Petitioner is fully competent and qualified to understand and protect the rights of the person she represents, and has no interests adverse to the interests of that person.

WHEREFORE, petitioner moves this court for an order appointing Jonee Fonseca as guardian ad litem for petitioner for the purposes of prosecuting this action against Defendants.

DATED: May 4, 2016

PACIFIC JUSTICE INSTITUTE

By: /S/ Kevin Snider
KEVIN SNIDER, ESQ.
ATTORNEY FOR PETITIONER

CONSENT OF NOMINEE

I, Jonee Fonseca, consent to act as guardian ad litem for the minor petitioner in the above action.

DATED: May 4, 2016

JONEE FONSECA

ORDER

The petition for an order appointing Jonee Fonseca as guardian ad litem for petitioner is GRANTED.

IT IS SO ORDERED.

DATED: _____

UNITED STATES DISTRICT JUDGE

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889-KJM-EFB **Amended Complaint for Declaratory Relief and Request for Temporary Restraining Order and Injunctive Relief**

INTRODUCTION

This action seeks emergency relief to save the life of a two-year-old child, Israel Stinson. (FRCP 65)

JURISDICTION

1. This Court has federal question jurisdiction over Plaintiffs' claims arising under the First, Fourth and Fourteenth Amendment of the United States Constitution and 42 U.S.C. 1983. Jurisdiction is therefore proper under 28 U.S.C. 1331. This Court has supplemental jurisdiction over Plaintiffs' claims arising under the Constitution of the State of California pursuant to 28 U.S.C. 1337.

VENUE

2. Venue is proper in the United States District Court for the Eastern District of California, pursuant to 28 U.S.C. sections 84 and 1391. The events that gave rise to this complaint are occurring in Roseville, Placer County, in the State of California, and one or more of the defendants has its Principal Place of Business in Roseville, Placer County, California.

PARTIES

3. JONEE FONSECA is an adult and a resident of the State of California. She is the mother of Israel Stinson. Pursuant to the California Family Code §6910 she is the healthcare decision maker for Israel Stinson, a minor. Jonee Fonseca is a devout Christian and believes in the healing power of God. She also believes that life does not end until the cessation of cardiopulmonary function. She has repeatedly requested that Israel not be removed from life support. She believes that removing Israel from the ventilator is tantamount to ending his life.

4. Defendant KAISER PERMANENTE ROSEVILLE MEDICAL CENTER—WOMEN AND CHILDREN'S CENTER (KPRMC) is a non-profit hospital corporation with its principal place of business in Roseville, California.

Plaintiff is informed and believes, and on the basis of said information and belief, alleges that KPRMC receives funding from the state and federal government which is used to directly and indirectly provide healthcare services to individuals including but not limited to Israel Stinson. This includes, but is not limited to, Medical and Medicaid monies.

5. Plaintiff is informed and believes that Defendant DR. MICHAEL MYETTE is a resident of Placer County in California. He is a Pediatric Intensivist at Kaiser Permanente Medical Center Roseville.

6. Defendant KAREN SMITH, M.D., serves as the Director of the California Department of Public Health. The Department which she heads has supervisorial, regulatory and enforcement roles over public hospitals, including KPRMC. Further, the Department issues death certificates, requires compliance by hospitals and physicians in the manner that the certificates are filled out and recorded. Defendant Smith's Department enforces the requirement that hospitals, including KPRMC, use California's definition of death and that determination of death be performed in a manner consistent with the State's statutory protocol. The Department that Dr. Smith runs works jointly with hospitals, coroners, and other physicians to ensure that determinations relative to death are made in a manner consistent with the State definition of death and pursuant to government protocol. The definitions and protocol are part of the State's Uniform Determination of Death Act. Dr. Smith is sued in her official capacity.

7. Plaintiffs are ignorant of the true names and capacities of defendants sued herein as Does 2 through 10, inclusive, and therefore sue these defendants by such fictitious names and capacities. Plaintiffs are informed and believe and based thereon allege that each of the fictitiously named defendants is responsible in some manner for the occurrences herein alleged, and that plaintiffs' injuries as herein alleged were proximately caused by the actions and/or in-actions of said Doe

defendants. Plaintiffs will amend this complaint to include the true identities of said doe defendants when they are ascertained.

8. At all times mentioned, each of the defendants was acting as the agent, principal, employee, and/or employer of one or more of the remaining defendants and was, at all times herein alleged, acting within the purpose, course, and scope of such agency and/or employment for purposes of respondent superior and/or vicarious liability as to all other defendants.

9. At all times mentioned herein, the defendants, and each of them, employed, hired, trained, retained, and/or controlled the actions of all other defendants, and each of them.

FACTS

10. On April 1, 2016 Plaintiff Fonseca took Israel to Mercy General Hospital ("Mercy") with symptoms of an asthma attack. The Emergency room examined him, placed him on a breathing machine, and he underwent x-rays. Shortly thereafter he began shivering, his lips turned purple, eyes rolled back and he lost consciousness. He had an intubation performed on him. Doctors then told Ms. Fonseca they had to transfer Israel to the University of California Davis Medical Center in Sacramento ("UC Davis") because Mercy did not have a pediatric unit. He was then taken to UC Davis via ambulance and admitted to the pediatric intensive care unit.

11. The next day, the tube was removed from Israel at UC Davis. The respiratory therapist said that Israel was stable and that they could possibly discharge him the following day, Sunday April 3. The doctors at UC Davis put Israel on albuterol for one hour, and then wanted to take him off albuterol for an hour. About 30 minutes later while off the albuterol, Israel's mother noticed that he began to wheeze and have trouble breathing. The nurse came back in and put Israel on the albuterol machine. Within a few minutes the monitor started beeping. The

nurse came in and repositioned the mask on Israel, then left the room. Within minutes of the nurse leaving the room, Israel started to shiver and went limp in his mother's arms. She pressed the nurses' button, and screamed for help, but no one came to the room. A different nurse came in, and Ms. Fonseca asked to see a doctor.

12. The doctor, Dr. Meteev, came to the room and said she did not want to intubate Israel to see if he could breathe on his own without the tube. Israel was not breathing on his own. Ms. Fonseca had to leave the room to compose herself. When Ms. Fonseca came back into the room five minutes later, the doctors were performing CPR on Israel. The doctors dismissed Israel's mother from the room again while they continued to perform CPR. The doctors were able to resuscitate Israel. Dr. Meteev told Ms. Fonseca that Israel was "going to make it" and that he would be put on Extracorporeal Membrane Oxygenation ("ECMO") to support his heart and lungs.

13. Dr. Meteev then indicated that there was a possibility Israel will have brain damage. He was sedated twice due to his blood pressure being high, and was placed on an ECMO machine and ventilator machine.

14. On Sunday April 3, 2016, a brain test was conducted on Israel to determine the possibility of brain damage while he was hooked up to the ECMO machine.

15. On April 4, 2016, the same tests were performed when he was taken off the ECMO machine. According to Israel's medical records, Israel was not in a coma at the time these tests were performed. The American Academy of Neurology guidelines require that patients be in a coma prior to performing a brain death exam. Prior to the first brain death examination, a UC Davis nurse contacted an organ donor company.

16. California Health and Safety Code §7180, which was in force and effect, at all times material to this action, provides that "An individual who has

sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

17. California Health and Safety Code §7181 provides that an individual can be pronounced dead by a determination of "irreversible cessation of all functions of the entire brain, including brain stem." It requires "independent" confirmation by another physician. Sections 7180 and 7181 are part of the Uniform Determination of Death Act.

18. On April 6, 2016, Israel was taken off the ECMO machine because his heart and lungs were functioning on their own. The next day, a radioactive test was performed to determine blood flow to the brain.

19. A UC Davis physician performed a second brain death exam on April 8, 2016, using the State's mandated definition and protocol relative to death. The doctor also did an apnea test, during which the ventilator was removed and Israel's CO2 levels were allowed to rise to dangerous levels in order to provoke a respiratory response. However, Israel was not comatose. The apnea test should never be done on patients who are not comatose, as the exam itself can lead to brain damage.

20. UC Davis officials informed Israel's parents that physicians would perform another brain death examination and apnea test to confirm the results of the exam conducted on April 8.

21. On April 11, 2016, Israel was transferred via ambulance from UC Davis to Defendant Kaiser Permanente Roseville Medical Center -- Women and Children's Center for additional treatment. Upon his arrival at KPRMC, another reflex test was done, in addition to an apnea test. On April 14, 2016, an additional reflex test was done for determination of brain death in conjunction with protocol

directed by the State of California and enforced by Defendant Smith's Department. That same day a certificate of death was issued.

22. The family was notified by KPRMC as per the State's directive found in Health and Safety Code §1254.4. The State of California requires KPRMC to adopt a policy for providing family or next of kin with a reasonably brief period of accommodation to gather family at the bedside of the patient after declaration of death pursuant to the standards mandated by the State. On information and belief, Plaintiffs allege that KPRMC has adopted such a policy as directed by the State of California.

23. With pulmonary support provided by the ventilator, Israel's heart and other organs are functioning well. Israel has also begun moving his upper body in response to his mother's voice and touch.

24. Israel has undergone certain tests which have demonstrated brain damage from the lack of oxygen. He is totally disabled at this time and is severely limited in all major life activities. Other than the movements in response to his mother's voice and touch, he is unable to feed himself or do anything of his own volition.

25. Defendants KPRMC, by and through its pediatric intensivist, Defendant Myette, has informed Plaintiff Jonee Fonseca that Israel is brain dead, utilizing the definition of "brain death" derived from Cal. Health & Safety Code §7180.

26. Plaintiffs are Christians with firm religious beliefs that as long as the heart is beating, Israel is alive. Plaintiff Fonseca has knowledge of other patients who had been diagnosed as brain dead, using the same criteria as in her son's case. In some of those cases, where the decision makers were encouraged to "pull the plug" yet they didn't, their loved one emerged from legal brain death to where they had cognitive ability and some even fully recovering. These religious beliefs involve

providing all treatment, care, and nutrition to a body that is living, treating it with respect and seeking to encourage its healing.

27. KPRMC has informed Jonee Fonseca that it intends to disconnect the ventilator that Israel Stinson is relying upon to breath claiming that he is brain dead pursuant to California Health and Safety Code §7180.

28. KPRMC claims that, since its medical doctors have pronounced Israel brain dead Jonee Fonseca has no right to exercise any decision making authority vis-a-vis maintaining her son on a ventilator.

29. Defendants have indicated that they wish to imminently remove life support from Israel.

30. Since April 15, Plaintiff Fonseca has made numerous efforts to secure an independent neurologist or other physician to examine Israel, pursuant to California Health and Safety Code §7181. Dr. Michel Accad, a cardiologist with the California Pacific Medical Center in San Francisco agreed to examine Israel on April 23 or 24, 2016. However, on April 23, he notified Ms. Fonseca that he would not be able to conduct the exam. Plaintiff Fonseca had contacted Dr. Paul Byrne, a board certified neonatologist, pediatrician, and Clinical Professor of Pediatrics at University of Toledo, College of Medicine. However, KPRMC would not allow Dr. Byrne to examine Israel or even be present during an examination, as he is not a California licensed physician.

31. Arrangements were made to transfer Israel to Sacred Heart Hospital in Spokane, WA, and a life flight via AirCare1was reserved to transport Israel to Spokane. For reasons unknown to his parents, Sacred Heart Hospital later decided not to receive Israel.

32. Plaintiff Jonee Fonseca has repeatedly asked that her child be given nutrition, including protein and fats. She has also asked that he be provided nutritional feeding through a nasal-gastric tube or gastric tube to provide him with

nutrients as soon as possible. She has also asked for care to be administered to her son to maintain his heart, tissues, organs, etc. KPRMC has refused to provide such treatment stating that they do not treat or feed brain dead patients. They have denied her ability to make decisions over the health care of her son. Plaintiff Fonseca has sought alternate placement of her son, outside the KPRMC's facility. She has secured transportation and is seeking alternative placement but requires time for that to occur. If KPRMC proceeds with its plans, Israel will expire.

33. Plaintiff Jonee Fonseca vehemently opposes the efforts of the Defendants to exclude her from the decision making regarding her son and their insistence that she has no right vis-a-vis the decision to disconnect the ventilator that provides oxygen necessary for her son's heart to beat and the organs to be kept profused with blood. Plaintiff Jonee Fonseca has expressly forbidden the hospital from removing life support. KPRMC has refused her requests for nutritional support and the placement of a tracheostomy tube and a gastric tube stating that she has no rights to request medical care for her son as he is brain dead. She has video evidence demonstrating Israel moving his upper body in response to her voice and touch. She also has a declaration from Dr. Paul Byrne that Israel is alive and not dead.

34. The State definition which Defendants are relying upon is in stark and material difference to the religious beliefs of Jonee Fonseca. Jonee believes that disconnection of the ventilator is tantamount to killing Israel.

35. Kaiser and UC Davis physician's were not exercising autonomous professional judgment. Instead, they were acting jointly, and/or on behalf of the State by carrying out the function of determining death in a manner that the State prescribes under the Uniform Determination of Death Act.

36. The State of California, acting by and through the Department of Public Health, has not authorized physicians to exercise independent professional judgment regarding determination of death. The State has specifically defined death and

KPRMC has jointly acted with the State to implement the determination that a patient – in this case Israel – is dead.

37. Plaintiffs are informed and believe and thereon allege that KPRMC and Dr. Myette have engaged in joint action with government officials to issue a death certificate for Israel on or about April 14, 2016.

38. Since the issuance of the death certificate, Israel has shown movement in direct response to the voice and touch of his mother.

39. Since the issuance of the death certificate, two physicians, independent of KPRMC and UC Davis have raised concerns that Israel may in fact be alive and would improve with treatment.

40. In that there is a dispute of fact between medical doctors, Israel's mother believes that she has a moral and spiritual obligation to give him the benefit of the medical doubt.

41. Officials with the State have jointly participated with KPRMC in implementing the policies and procedures surrounding the determination and processing of Israel's death.

42. Moreover, there is a significant nexus between the actions of KPRMC, Dr. Myette and the Department of Public Health.

FACTS WARANTING EMERGECY TEMPORARY RESTRAINING ORDER AND INJUNCTIVE RELIEF

43. There is a substantial likelihood of success on the merits given the wealth of decisional authority, both in the Court of Appeal, and the U.S. Supreme Court demonstrating the constitutional rights people have over their decision making role in their healthcare and for parents over the healthcare decisions concerning their children

44. The injuries threatened of the conduct is not enjoined will be

irrevocable and irreparable, Israel Stinson will be taken off a ventilator, his heart will stop beating and he will cease to show any signs associated with a living body. If Ms. Fonseca is prohibited from making healthcare decisions re nutrition, medications, etc., her son will starve and the electrolytes will get out of balance and other complications will arise that will hasten, and ultimately lead to, Israel's death.

45. The threatened injury is death to Israel and loss of a son to Jonee. Defendants have stated no reason they would suffer a loss.

46. This case is one of national interest and the issue of the right to participate in healthcare decisions is one of great public concern. Therefore, granting of preliminary injunction is in the public interest.

TERMS OF THE PROPOSED RESTRAINING ORDER

47. Plaintiffs seek to have KPRMC restrained from removing the ventilator.

48. Plaintiffs seek to have KPRMC initiate the provision of nutrition to Israel.

49. Plaintiffs seek to have to take all medically available steps/measures to seek to improve Israel's health and prolong his life, including nutrition and including the insertion of a tracheostomy tube and a gastric tube.

50. Plaintiff seeks to be provided ample time and support (including the placement of the tracheostomy tube and the gastric tube) to try and locate a facility that will accept Israel as a patient to treat him and provide him vent support

FIRST COUNT

Deprivation of Life in Violation of Due Process of Law under the Fifth and Fourteenth First Amendments (42 U.S.C. 1983)

Against All Defendants

51. The Plaintiffs incorporate by reference as if fully set forth herein the foregoing paragraphs.

52. The aforementioned conduct was done under color of state law and by state actors.

53. Defendant Smith is an official serving the State of California. The Department that she heads has created and dispatched to physicians and hospitals, including Defendants KRPMC and Dr. Myette, a mandatory form known as a Certificate of Death – State of California. Acting pursuant to the Uniform Determination of Death Act, she requires that medical doctors and hospitals, including co-defendants, use the operational definition of death found in Health & Safety Code §7180 and that procedures be followed under Health & Safety Code §7181 and that recordation be provided on the Certificate of Death. Pursuant to Health & Safety Code §7183 she requires that KPMRC maintain records, in accordance to regulations that her Department adopts, regarding individuals who have been pronounced dead at the KPMRC facility under the definition of death found Uniform Determination of Death Act. Further, her Department also requires that KPRMC fill out the Certificate of Death within 15 hours after death under (Health & Safety Code §102800) and that KPRMC register the death with local officials (Health & Safety Code §102775). All of the conduct is done jointly and cooperatively with KPRMC and its physicians and under color of law and, as to Dr. Smith and those under her supervision, by state actors.

54. Defendant KPRMC hires medical doctors. When there is a medical crisis and there is a belief that death has or may have occurred, KPRMC's doctors use the operational definition of death provided by the State of California. They perform examinations to test for death under the State's protocol. KPRMC physicians do not exercise independent medical judgments as private actors. They act as the arm of the State by performing these tasks under the mandated State definition and protocol regarding death. These activities related to determination of death are so joined and intertwined with the State that the conduct cannot be

reasonably deemed a mere private decision not fairly attributable to the State.

55. In the tragic events described in this Amended Complaint, KPRMC and Dr. Myette used the power, possessed by virtue of state law, to perform tests to determine that Israel is deceased using the definition of death mandated by California. They have acted in conjunction with government officials because they have been clothed with the authority of state law. Hence, for purposes of determining death, there actions are done under color of state law.

56. Under the Fourth and Fourteenth Amendments, Israel cannot be deprived of life without due process of law. Historically, death has been defined as the cessation of breath and the beating of the heart. Such understanding was true at the ratification of said Amendments. The State of California has defined death in a matter that is broader than the historical definition. The State's statutory scheme related to the definition of death and how it is determined have provided no procedures or process by which a patient or their advocate can independently challenge the findings of death. Further, the statutory scheme removes the independent judgment of medical professionals as to whether a patient is dead.

57. Such is the case in the facts described in this Amended Complaint. Israel has been determined to be dead, but the State of California provides no means to challenge that finding. Under the facts described herein, there is a medical dispute of fact as to whether Israel is dead or alive. On this Earth, there can be few rights more precious than the liberty interest in life.

58. Defendants, and each of them, acting jointly and in concert, are seeking to deprive Israel of his right to life without due process of law.

59. In addition to the injunctive relief described herein, Plaintiffs seek declaratory relief from the Court that the Uniform Determination of Death Act is unconstitutional on its face for failing to provide due process.

SECOND COUNT

Deprivation of Parental Rights in Violation of Due Process of Law under the Fifth and Fourteenth First Amendments Rights (42 U.S.C. 1983)

Against All Defendants

60. Plaintiffs incorporate by reference as if fully set forth herein the foregoing paragraphs.

61. As the fit parent of Israel, Plaintiff Jonee Fonseca has plenary authority over medical decision relative to her 2-year-old child.

62. In addition to the natural profound bounds of affection between parent and child, Israel's mother believes that she has a moral and spiritual obligation to give her child every benefit of the medical doubt before disconnecting life support.

63. Because there is a dispute of facts between medical professionals as to whether Israel is dead of alive, Jonee Fonseca seeks to have her child remain on life support, have appropriate medical treatment so that his condition does not further deteriorate, and have him transported to a medical facility that shares her view that he is not dead.

64. The Uniform Determination of Death Act provides no due process for a parent to contest the medical findings by bringing in her own physician for a second opinion. Because as a fit parent she is completely cut off under the State's protocol, she is being deprived of her parental rights which could result in the imminent death of her son.

65. Defendants, and each of them, are acting jointly and in concert and under color of state law.

66. In addition and in the alternative, there is a close nexus between the conduct of KPRMC, Dr. Myette and the State of California.

67. In addition to the injunctive relief described herein, Plaintiffs seek declaratory relief from the Court that the Uniform Determination of Death Act is

unconstitutional on its face for failing to provide due process.

THIRD COUNT

Emergency Medical Treatment and Active Labor Act (42 U.S.C. Section 1395dd et seq.) – Against KPRMC

68. Plaintiffs reincorporate and re-allege the preceding paragraphs as though fully set forth herein.

69. Defendant KPRMC is a hospital subject to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. Section 1395dd et seq. ("EMTAALA").

70. On April 11, 2016, Israel was transported via ambulance and presented to KPRMC with an emergency medical condition.

71. At the time Israel was presented to KPRMC, KPRMC obtained actual knowledge that he was experiencing an acute medical condition that required immediate medical attention and that, if left untreated or inadequately treated, would have led to material deterioration of his condition.

72. Within a few days of receiving Israel in his emergency medical condition, KPRMC violated its duty under the EMTAALA by taking steps to de-stabilize his condition.

73. Specifically, KPRMC has sought, and continues to seek, to remove Israel from life-sustaining treatment, including the ventilator.

74. KPRMC's active and ongoing efforts to de-stabilize Israel's condition prompted Plaintiff to first seek judicial relief on April 14, 2016, just three days after Israel was transported to KPRMC.

75. In violation of its transfer obligations under the EMTAALA, KPRMC further seeks to transfer Israel not to another hospital or qualifying institution, but to the custody of the coroner who will not provide stabilizing or life-sustaining treatment.

76. Israel has suffered, and will continue to suffer, grave personal harm

unless the Defendants are enjoined from materially de-stabilizing Israel's condition.

77. Plaintiffs pray for a declaration that Defendant KPRMC has violated EMTAALA.

78. Plaintiffs further pray for relief in the form of monetary damages, in an amount according to proof, for the harm suffered as a direct and proximate cause of KPRMC's violation of the EMTAALA.

79. Plaintiffs pray for an injunction prohibiting Defendants from removing ventilator support and an order that they institute nutritional support and other medical treatments so as to provide him with proper care and treatment designed to promote his maximum level of medical improvement, to insert a tracheostomy tube and a gastric tube, and to provide Plaintiff a reasonable time to locate an alternate facility to care for her child in accordance with her religious beliefs.

FOURTH COUNT

Violation of Fifth Amendment Rights - Privacy Rights

(42 U.S.C. 1983)

Against KPRMC and Myette

80. Plaintiffs incorporate, herein by reference, the foregoing paragraphs.

81. This action arises under the United States Constitution, particularly under the provisions of the Privacy Rights established and recognized as existing within and flowing from Fourth Amendment to the Constitution of the United States.

82. Each of the acts complained of herein was committed by the Defendants, and each of them, and by seeking to deny Jonee Fonseca and Israel Stinson of the rights to privacy including but not limited to their rights to have control over their health care, by refusing to provide health care to them, and by denying them the right to have control over the health care decisions affecting Israel, which are recognized under the Fourth Amendment of the U.S. Constitution.

83. The conduct of KPRMC and Dr. Myette, and each of them, has deprived Plaintiffs of the rights of privacy that they have over their medical decisions, to Plaintiffs' injury.

84. They have acted under color of law.

FIFTH COUNT

Violation of Fifth Amendment Rights - Privacy Rights

CA Const. Art. I

Against KPRMC and Myette

85. Plaintiffs incorporate, herein by reference, the foregoing paragraphs.

86. This action arises under the personal autonomy rights of privacy found in the California Constitution.

87. Each of the acts complained of herein was committed by KPMRC and Dr. Myette by seeking to deny Jonee Fonseca and Israel Stinson of the rights to privacy including but not limited to their rights to have control over their health care, by refusing to provide health care to them, and by denying them the right to have control over the health care decisions affecting Israel.

88. The conduct of KPRMC and Dr. Myette, and each of them, has deprived Plaintiffs of the rights of autonomy privacy to Plaintiffs' injury.

PRAYER

Wherefore, Plaintiffs pray for judgment against the Defendants as follows:

1. An emergency order, temporarily restraining KPRMC from removing of ventilator support and mandating introduction of nutritional support, insertion of a tracheostomy tube, gastric tube, and to provide other medical treatments and protocols designed to promote his maximum level of medical improvement and provision of sufficient time for Janee Fonseca to locate an alternate facility to care for her child in accordance with her religious beliefs;

2. A preliminary and permanent injunction including, but not limited, to injunctions precluding removal of ventilator support and mandating introduction of nutritional support, insertion of a tracheostomy tube, gastric tube, and to provide other medical treatments and protocols designed to promote his maximum level of medical improvement and provision of sufficient time for Israel Stinson to locate an alternate facility to care for her child in accordance with her religious beliefs;

3. A declaration that the Uniform Determination of Death Act is unconstitutional on its face for failing to provide due process of law;

4. Plaintiffs also request that the Court issue whatever additional injunctive relief the Court deems appropriate;

5. Damages against KPRMC;

6. Any and all other appropriate relief to which the Plaintiffs may be entitled including all "appropriate relief" within the scope of F.R.C.P. 54(c); and,

7. Costs and attorney fees

Dated: May 3, 2016

/S/ Kevin Snider
Kevin T. Snider
Attorney for Plaintiffs

05/03/2016	28	MINUTES (Text Only) for proceedings before Magistrate Judge Carolyn K. Delaney: SETTLEMENT CONFERENCE held on 5/3/2016. After negotiations, CASE NOT SETTLED. The Court set a follow-up informal conference call for 5/9/2016 at 10:00 AM before Magistrate Judge Carolyn K. Delaney. Parties are instructed to use the following to access the conference call: 877-848-7030 (dial), 7431521 (access code). Plaintiffs Counsel Alexandra Snider, Seth Kraus present. Defendants Counsel Jason Curliano present. (Owen, K) (Entered: 05/03/2016)

05/02/2016	23	MINUTE ORDER issued by Courtroom Deputy C. Schultz for District Judge Kimberly J. Mueller ORDERING a Settlement Conference SET for May 3, 2016 at 1:30 PM in Courtroom 24 before Magistrate Judge Carolyn K. Delaney. As soon as practical, the parties are directed to submit confidential statements, not to exceed five pages, to Magistrate Judge Delaney's chambers using the following email address: ckdorders@caed.uscourts.gov. Such statements are neither to be filed with the Clerk nor served on opposing counsel; however, each party shall e-file a one page document entitled Notice of Submission of Confidential Settlement Conference Statement. Each party is reminded of the requirement that it be represented in person at the settlement conference by a person able to dispose of the case or fully authorized to settle the matter at the conference on any terms. See Local Rule 270 (Text Only Entry) (Schultz, C) (Entered: 05/02/2016)

05/02/2016	22	MINUTES for further proceedings as to Plaintiff's Motion for TRO held before District Judge Kimberly J. Mueller on May 2, 2016. Plaintiff's Counsel, Kevin Snider, present. Plaintiff, Jonee Fonseca, present at counsel table. Defendants' Counsel, Jason Curliano, present. Plaintiff was granted until close of business on May 3, 2016 to file an amended complaint. A settlement conference will be set for May 3, 2016 at a time to be determined. The court set a Preliminary Injunction briefing schedule and hearing as follows: Plaintiff's motion shall be filed by noon on May 6, 2016, Defendants' opposition shall be filed by noon on May 10, 2016, and a hearing is set for 5/11/2016 at 3:30 PM in Courtroom 3 before District Judge Kimberly J. Mueller. The briefing is limited to 20 pages each. If a party anticipates presenting evidence/calling witnesses, they should include that information in their briefing and provide estimates for the time needed. The April 28, 2016 Order (ECF No. 9) issued by District Judge Troy L. Nunley remains in effect. Court Reporter: Kimberly Bennett. (Text Only Entry) (Schultz, C) (Entered: 05/02/2016)

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Counsel of record
Michael J. Peffer, State Bar. No. 192265
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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: 2:16-CV-00889 DECLARATION OF ALEXANDRA SNYDER REGARDING DR. ZABIEGA'S STATEMENT AND CREDENTIALS.

DECLARATION OF ALEXANDRA SNYDER

I, Alexander Snyder, declare as follows:

I am an attorney admitted to the State Bar of California (SL# 252058), and am not a party to the above-encaptioned case. If called upon, I could and would testify truthfully, as to my own personal knowledge, to the following:

1. I received the attached statement and CV from Dr. Thomas Zabiega on May 2, 2016.

2. Attached as Exhibit 1 to this declaration is a true and correct copy of Dr. Thomas Zabiega's statement regarding his assessment of two videos showing Israel making "purposeful movements" in response to "tactile stimulation."

3. Attached as Exhibit 2 is Dr. Zabiega's CV stating that he is a Board Certified Neurologist who is licensed in Illinois, Indiana, and Michigan.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 2nd day of May, 2016 in Roseville, CA.

_S/ Alexandra Snyder
Alexandra Snyder, Declarant

EXHIBIT 1

THOMAS MARK ZABIEGA, M.D.
391 Clubhouse Street
Bolingbrook, IL 60490
Tel. (630) 768-4590
e-mail: tzabiega@hotmail.com

EMPLOYMENT:

2015- **Attending Neurologist, Franciscan Hammond Clinic,** Munster, Indiana (with privileges at Saint Margaret Mercy Medical Center, Franciscan Physicians' Hospital, and Community Hospital of Munster)

2013-2015 **Attending Neurologist, Dreyer Medical Clinic,** Aurora, Illinois (with privileges at Rush Copley Medical Center and Presence Mercy Medical Center).

2007-2013 **Attending Neurologist, Joliet Headache and Neuro Center,** Joliet, Illinois (with privileges at Presence Saint Joseph's Medical Center and Silver Cross Hospital in Joliet and Morris Hospital in Morris, IL).

2003-2007 **Attending Neurologist, Joliet Pain Care Center,** Joliet, Illinois

2000-2003 **Resident Physician, University of Chicago Hospitals Department of Neurology**

1999-2000 **Resident Physician, West Suburban Hospital,** Oak Park, Illinois

EDUCATION:

2000-2003 **University of Chicago Hospitals Neurology Residency Program**

1999-2000 **West Suburban Hospital, Oak Park, Illinois Transitional Year Residency Program**

1995-1999 **Southern Illinois University School of Medicine.** M.D.

1991-1995 **Southern Illinois University at Carbondale**
B.A., Physiology, *magna cum laude*, University Honors Program

CERTIFICATION:

Sept. 2006 **Diplomate of the American Board of Psychiatry and Neurology**

April 2000 **United States Medical Licensing Examination, Step III**

Aug. 1998 **United States Medical Licensing Examination, Step II**

June 1997 **United States Medical Licensing Examination, Step I**

LICENSURE

Since 2002	**Illinois State Medical License #036-106124**
Since 2004	**Indiana State Medical License #01059016A**
Since 2015	**Michigan State Medical License #4301106690**

HONORS AND AWARDS:

1998	**Neurology Clerkship Honors. Southern Illinois University School of Medicine.**
1997	**Obstetrics/Gynecology Clerkship Honors. Southern Illinois University School of Medicine.**
1995	**Southern Illinois University's 25 Most Distinguished Seniors**
1995	**Liberal Arts and Sciences Honors Society.** Top 10% of graduating class for Southern Illinois University.
1993	**Sphinx Club.** Southern Illinois University's oldest and most prestigious honors society.
1993-94	**Charles D. Tenney Memorial Scholarship.** Full tuition scholarship for outstanding achievement in the University Honors Program.
1993	**Undergraduate Student Government Special Activity Scholarship.** Merit award for leadership.
1993	**Southern Illinois University Sophomore of the Year Award**
1992	**Southern Illinois University Freshman of the Year Award**

PUBLICATIONS

2012	**Part of the Ad-Hoc PEG Tube Study Group that wrote the article: "When to Recommend a PEG Tube," *The Linacre Quarterly*, February 2012, Vol. 79, No. 1, pp. 25-40.**
2010	**Patrick Guinan, Thomas Zabiega, Christine Zainer, "Pastoral Care: The Chicago Study," *The Linacre Quarterly*, May 2010, Vol. 77, No. 2, pp. 175-180. Reprinted in: *Dolentium Hominum* [Journal of the Pontifical Council for Health Care Workers], No. 75, Year XXV (2010), No. 3., pp. 60-62, and *Catholic Medical Quarterly*, May 2011, Vol. 61, No. 2, pp. 33-37.**

2006-2008 **Author of regular column "Our Health" in the Polish language monthly *Katolik*, published by the Catholic Archdiocese of Chicago**

2004-2012 **Chapter 19 entitled "Neurology" in *The Ultimate Guide to Choosing a Medical Specialty,"* Brian Freeman, ed. Lange Medical Books/McGraw-Hill, New York, 2004, 2nd ed. 2007, 3rd ed. 2012.**

TEACHING

April 26,2006 **Guest Lecturer at Medical Workshop organized by Wright College, Chicago, Illinois.**

April 1, 2006 **Lecturer at 2nd Annual Midwest Regional Bioethics Conference of the Catholic Medical Association (held in Milwaukee, Wisconsin)**

April 7, 2005 **Lecturer for the Integritas Institute of the University of Illinois at Chicago (UIC) at end-of-life care seminars held at the UIC Newman Center and the UIC College of Nursing**

2003 **Visiting Instructor, University of Chicago's BIOSCI 14107 *Workings of the Human Brain* undergraduate course**

RESEARCH

1994-1995 **Undergraduate Honors Thesis Research.** Researched Polish-Ukrainian historical relations under the supervision of Prof. Edward J. O'Day, Department of History, Southern Illinois University, and wrote a thesis entitled: "Battle for the City of Lions: The Lwow Episode of the Polish-Ukrainian War, November 1-22, 1918."

1992-1993 **Research Assistant** for Luciano Debeljuk, M.D. and Andrzej Bartke, Ph.D., Chairman, Department of Physiology, Southern Illinois University School of Medicine. Analyzed the effect of substance P and neurokinin A on luteinizing hormone in normal and transgenic mice. Also explored the effect of clonidine on luteinizing hormone levels in hamsters.

HOSPITAL ACTIVITIES:

2008-2010 Ethics Committee, Provena Saint Joseph's Medical Center, Joliet, IL

2008 Revised the Brain Death Criteria for Morris Hospital, Morris, IL

2010 Revised the Brain Death Criteria for the Provena Saint Joseph's Medical Center and the Provena Health System in Illinois.

PROFESSIONAL AFFILIATIONS:

Catholic Medical Association

Catholic Physicians' Guild of Chicago

Society of Catholic Social Scientists

COMMUNITY ACTIVITIES:

2004-2009 **Catholic Medical Association, Regional Director, Region VII (Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin)**

2003-2009 **Catholic Physicians' Guild of Chicago, Vice President**

2005-2009 **Midwest Regional Bioethics Conferences of the Catholic Medical Association:** Conference Chair of the 2005 (Mundelein, IL), 2007 (Mundelein, IL), and 2009 (Notre Dame, IN) conferences.

1998-1999 **Academic Peer Tutoring Program.** Organized tutoring program at Southern Illinois University for medical students.

1998-1999 **Pharmaceutical Assistance Program.** Assisted low income patients in filing for and receiving free medications from pharmaceutical companies.

1997-1998 **Scope: Literary and Artistic Medical School Journal.** Evaluated works of literature submitted for publication.

1992-1995 **Beta Beta Beta Biological Honors Society, Iota Zeta Chapter.** President, Historian, and co-founder.

1992-1995 **International Business Association.** President and Treasurer.

1992-1995 **Premedical Professions Association.** Premedical Chair and co-founder.

1992-1995 **International Student Council.** Representative of the International Business Association. Member of Executive Oversight Committee. Co-organized and coordinated several International Festivals at Southern Illinois University.

1992 **Undergraduate Student Government.** Member of Election Commission.

PERSONAL

Married since 2005 with 5 children

Fluent in Polish

Hobbies include history, reading, international affairs, soccer.

EXHIBIT 2

May 1, 2016

Re: Israel Stinson

To Whom It May Concern:

I am a licensed board certified neurologist in the States of Illinois, Indiana, and Michigan in full time practice for 13 years.

I have reviewed the publicly available information on Israel Stinson's case but have not been able to examine the patient or review the medical record at this time.

I am aware that two year old Israel initially suffered an asthma attack on April 1, 2016, required resuscitation and has been declared "brain dead." I am also aware that he was given three apnea tests* in the clinical examination process resulting in the declaration of "brain death."

I have observed two videos made subsequent to this clinical declaration of "brain death," showing his movements during touching, tickling, and talking to him by his mother. The movements occur with simultaneous tactile and verbal stimuli and while I cannot definitely state that the child is responding to verbal stimuli alone, he most definitely is moving in response to tactile stimuli. These movements are purposeful because he is moving side to side, away and back to the area of the stimulus, whether the stimulus is on his left side (first movie) or his right side (second movie). This child, with these purposeful movements does not fulfill the brain death criteria of the American Academy of Neurology (AAN) used for adults whose brains are considered less plastic, less resilient to injury than young children.

Some movements in some "brain dead" patients have been attributed to "spinal reflexes" without invalidating the clinical diagnosis. However, a spinal reflex given these tactile stimuli would only result in subtle muscle contractions of the abdomen. While with this child, you have a very obvious movement (especially in the second movie, where the child's body is more fully visible) of the child moving away from the tickling and then back (in fact, very much like a child would react in deep sleep). If I pinch a patient and he makes that type of movement (very specific to the stimulus--not some generalized movement), it is my professional assessment that he not only has intact brainstem function, but cortical function as well. Again it is an appropriate response of a patient with intact cortical function (for example a normal person sleeping) to a mildly noxious stimulus (like tickling).

I am also aware that these movements occurred ~1 week after receiving thyroid hormone medication at the family's request. The exact medication, dosing regimen, and test results are unknown to me other than that there was evidence of low thyroid function and that the patient's hypothyroid condition was not initially treated.

It is interesting to note that purposeful movements began occurring not only after the declaration of brain death, but ~ 1 week after thyroid hormone supplementation was given which would be consistent with the onset of action of some thyroid medications. Others have shorter onset times.

Low thyroid hormone can affect consciousness, respiration, and reflexes, in fact, functioning of the entire brain including respiratory centers in the brainstem. With an underlying or acute hypothyroidism, such as lack of oxygen to the brain which results in low thyroid hormone levels, clinical "brain dead" tests showing lack of functioning of the brain would be invalid. According to the AAN, severe endocrine abnormalities must be excluded. Even if unconsciousness or lack of breathing were not primarily due to an endocrine abnormality, but only made worse by a hypothyroid condition as a result of the brain injury, empiric testing and optimizing treatment, a matter of life and death for this young patient, is reasonable and warranted.

In addition, I am aware that Israel's only nutrition has been dextrose (sugar) intravenously for the last month. This is inadequate nutrition for healing, especially of the brain. Brain function is affected by nutrition.

As a neurologist I can tell you that the brain takes a long time to recover, and I have seen patient's come out of states which were considered irreversible after several weeks or months.

* The apnea test is used to test for the brainstem's ability to stimulate breathing. The apnea test is done by disconnecting the patient's breathing tube from the ventilator for up to 10 minutes or longer while the clinician makes his/her clinical assessment as to whether any breathing efforts were made by the patient. Even if oxygen is flowed into the lungs via the breathing tube and absorbed by the blood, the acid waste product, carbon dioxide, increases and is not removed. It is the rationale of the apnea test to let carbon dioxide rise. While higher than normal levels of carbon dioxide may stimulate the respiratory centers in the brainstem of a normal person to send signals to the respiratory muscles to take a breath, there are many documented problems and risks with the apnea test. The increase in blood carbon dioxide (blood acid) will do nothing for a patient with an already injured brain except harm them. Why? Because increases in carbon dioxide to levels required by the apnea test, in a patient with an already injured brain, make brain swelling worse, risking more damage to these structures, and less ability of these structures to respond normally and demonstrate "functioning." Brain tissue that may not be "functioning" but is still viable and recoverable before the apnea test may be irreversibly damaged after the test. In addition, high carbon dioxide levels can cause sedation ("CO2 narcosis") and other complications.

If requested by the family or court, I would be happy to testify.

Thomas M. Zabiega, MD
Franciscan Hammond Clinic
759 45th Street, Suite 104
Munster, Indiana 46321
(630) 768-4590
tzabiega@hotmail.com

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Counsel of record
Michael J. Peffer, State Bar. No. 192265
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Email: ksnider@pji.org

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO REQUEST FOR TEMPORARY RESTRAINING ORDER AND FURTHER INJUNCTIVE RELIEF** **Date:** May 2, 2016 **Time:** 1:30 p.m. **Ctrm:** 3 **Hon.:** Kimberly J. Mueller

INTRODUCTION

Counsel for Plaintiffs submits this reply to Defendants' (herein "Kaiser") opposition to the temporary restraining order and further injunctive relief.

ARGUMENT

A. Only the *success on the merits* prong is challenged

There are four prongs that must be established for a temporary restraining order and preliminary injunction. They are:

- Likelihood of success on the merits;
- Likelihood that the plaintiff will suffer irreparable harm in the absence of relief;
- The balance of the equities tips sharply in the plaintiff's favor; and,
- The injunction is in the public interest.

In its opposition Kaiser only challenges the first prong, i.e., likelihood of success on the merits.

B. The request to preserve the status quo meets the serious questions test.

Under *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127 (9th Cir. 2011), the Ninth Circuit explained that there is a sliding scale regarding the four prongs when deciding whether to preserve the status quo. It is necessary that "serious questions going to the merits were raised and the balance of hardships tips sharply in plaintiffs favor." Id. at 1131-32. Here there is no question regarding the hardships tipping sharply in favor of the Plaintiffs. Plaintiffs now turn to the serious question test.

1. Kaiser challenges the serious question based on the state actor requirement.

Fairly read, the complaint brings claims under 42 U.S.C. 1983. Kaiser argues that it is not a state actor and therefore a 1983 claim cannot be brought.

Under *Lugar v. Edmonson Oil Co.*, 457 U.S. 922 (1982), the Supreme Court explained that "state action" is present when "private persons, jointly engaged with state officials in the prohibited action, are acting 'under color' of law for purposes of the statute. To act 'under color' of law does not require that the accused be an officer of the State. It is enough that he is a willful participant in joint activity with the State or its agents." Id., at 943.

The facts of *Lugar* are instructive. A truck stop operator was allegedly indebted to a supplier. Under a state statute, the supplier went ex parte to the courthouse and obtained a writ of attachment. This should not be confused with ex parte appearances in California Superior or Federal Courts. Under the statute, an individual merely goes to the courthouse and receives a writ of attachment from a clerk. The writ of attachment is served on the debtor by the Sheriff, though the debtor retains custody of his property. The truck stop owner was cleared of the matter but brought suit in federal court against the supplier under 1983. The District Court dismissed the case for lack of a state actor and the Fourth Circuit Court of Appeals affirmed.

The Supreme Court disagreed. Although the majority of the conduct was carried out by the supplier, the supplier's actions and that of the court clerk and Sheriff was sufficient because the supplier, court clerk, and Sheriff, were acting according to a Virginia statute.

In the present case before this Court, the complaint alleges that Kaiser's conduct is performed pursuant to the statutory scheme. Indeed, Kaiser has provided much detail about the scheme. Kaiser is not acting at its own private whim. It is engaging in conduct by statutory directive.

The conduct in question revolves around the "death event." What is meant by that is when someone – such as Israel – is having a medical crisis, physicians operate under a definition of *death* mandated by California (Health & Safety Code

§7180). Next, physicians perform tests to determine if the patient is brain dead. (Health & Safety Code §7181). Per statute, that test is performed twice. Id. After determination of death, the family is notified and life support removed under procedures described in Health & Safety Code §1254.4. Though not discussed in Kaiser's brief, the State provides the hospital with a death certificate form which must be filled out in part by the physician in accordance with State requirements. That form is eventually dispatched to the County Coroner. In Placer County, the Coroner typically takes custody of the body from the hospital. The hospital must then communicate with the State of California within eight days of determination of death.

Here the State has orchestrated the protocol by its statutory scheme. Kaiser is correct that it is merely reading and playing the score that has been given it by the State. In that the actions of Kaiser are so intertwined with the State, the *state action* standard in this case equals to, or is greater than, the facts in *Lugar v. Edmonson Oil Co.* Hence, the state actor element is present in this case. At the very least, such presents a serious question as to whether the State has intertwined itself in the death event such that Kaiser is a state actor under the *Lugar* doctrine.

2. The Complaint raises serious questions by challenging the statutory scheme.

Fairly read, the Complaint raises the claim that medical decisions, including the right when to end life, is part of the general right to privacy under the due process clause.

Plaintiffs challenge a statutory scheme relative to the death event. Kaiser has noted – correctly – that "historically, death has been defined as the cessation of heart and respiratory functions." Kaiser Brief at p. 10. California's statutory scheme broadens the definition of *death*. However, neither the patient nor the patient's representative is provided any mechanism to challenge the findings.

"No State shall make or enforce any law which shall…deprive any person of life…without due process of law." U.S. Const. Fourteenth Amendment. Here the statutory scheme expedites the determination of death by not including cessation or breathing and heartbeat within the definition. This lessoned standard of death provides no process by which the patient's advocate can obtain a different independent medical opinion by the physician of her choosing or even challenge the findings. This raises a serious question of law which requires that the status quo be preserved until resolved.

The Plaintiffs challenge the statutory scheme for another reason. A parent naturally has a profound emotional bound with her child. In addition to that, this parent – Jonee Fanseca – believes she has a moral and spiritual obligation to give her child every benefit of the doubt before disconnecting life support. In the present case, the facts are that the parent has a sincerely help religious belief that life does not end until the heart ceases to beat. Moreover, Israel responds to her voice and touch. On occasion, Israel has apparently taken breathes on his own. Additionally, the facts are that a physician believes that the child is not dead and Israel's condition can improve with further treatment.

Typically, a fit parent has plenary authority over medical decisions for a small child. As stated above and further articulated in her pro per filings in the Superior Court, Jonee Fonseca has a moral and spiritual obligation to give her child every benefit of the medical doubt as to whether the child is in fact dead or can improve with additional treatment. Under the facts in the complaint, she seeks to exercise her peragative. However, Kaiser is bound by the State scheme for a death event. The scheme excludes this parent from any due process in the decision making. This raises serious legal questions under *Alliance for the Wild Rockies*.

Finally, due to the extremely short timeframe in which to file an emergency motion with the Court, counsel for Plaintiffs did not have the luxury of fleshing out

in detail the legal theories. It is proper to preserve the status quo and allow Plaintiffs to exercise their rights under the federal rules to amend the complaint and to file notice with the Attorney General that the statutory scheme is challenged. The Attorney General, if she so chooses, can appear to defend the scheme.

C. The abstention doctrine is not applicable.

Kaiser also urges the Court to disrupt the status quo based on the abstention doctrine. That doctrine does not apply because the claims in the federal complaint and described above were never raised or briefed. Jonee Fanseca is a 23-year-old mother who filed a "petition" in state court. Although the Superior Court graciously considered the paper as a "complaint," the undersigned is not aware of any points and authorities being filed with Superior Court by her. Her pro bono attorney, Alexandra Snyder, has come rather recently into the State Court proceedings. However, she has not had opportunity to brief the matter. Instead, the lower court has merely allowed its TRO to expire based upon its own terms. The State Court did not order further briefing of the case and noted that a federal court case has been filed and the parties are pursing their rights there. Under these procedural facts, the abstention doctrine described in *Colorado River Conservation Dist. V. U.S.*, 424 U.S. 800 (1976), is not appropriate.

CONCLUSION

Plaintiffs have raised serious legal questions. Because disruption of the status quo would be profound and irreversible, the equities tip sharply in Plaintiffs' favor.

S/ Kevin Snider
Kevin Snider, attorney for Plaintiffs

Kevin T. Snider, State Bar No. 170988
Counsel of record
Michael J. Peffer, State Bar. No. 192265
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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB NOTICE OF PROCEEDINGS AND ORDERS IN SUPERIOR COURT; DECLARATION OF ALEXANDRA SNYDER

DECLARATION OF ALEXANDRA SNYDER

I, Alexander Snyder, declare as follows:

1. I am an attorney admitted to the State Bar of California (SL# 252058), and am not a party to the above-encaptioned case. If called upon I could and would testify truthfully, as to my own personal knowledge, as follows:

2. What follows is a true and correct account of the orders and proceedings before the Placer County Superior Court.

3. Jonee Fonseca, Israel Stinson's mother, filed a petition for a temporary restraining order to keep her son on life support at Kaiser Permanente Roseville Medical Center ("Kaiser") pro se on April 14, 2016. Time was of the essence, as Kaiser had indicated the hospital would remove the ventilator from her son that afternoon.

4. I accompanied Ms. Fonseca in an appearance before Placer County Superior Court Judge Alan V. Pineschi. Judge Pineschi granted the TRO and set a hearing for the following morning, April 15, 2016 before Judge Michael W. Jones.

5. At the April 15 hearing, Ms. Fonseca requested a two-week extension of the TRO in order to locate a physician who could provide an independent examination of her son pursuant to CA Health and Safety Code § 7181. Kaiser stated that they would only provide admitting privileges to a California-licensed neurologist, preferably a pediatric neurologist.

6. Judge Jones granted a one-week extension of the TRO to locate a pediatric neurologist and set a hearing for April 22, 2016.

7. On April 22, 2016, Ms. Fonseca believed that Dr. Peter Graves at Sacred Heart Hospital in Spokane, WA would admit Israel for treatment. A life flight with AirCARE One was secured and paid for to transport Israel to the hospital in Spokane. Dr. Myette spoke with AirCARE One to confirm the transport.

8. Judge Jones issued an order directing Kaiser to release Israel to Sacred Heart Hospital and set a hearing for April 27, 2016.

9. For reasons unknown to myself or to Ms. Fonseca, Sacred Heart Hospital decided not to accept Israel as a transfer patient.

10. At the April 27 hearing, I submitted the previously filed statement by Dr. Paul Byrne, a Board Certified Neonatologist, Pediatrician, and Clinical Professor of Pediatrics. Dr. Byrne is a member of the American Academy of Pediatrics and founded the Neonatal Intensive Care Unit at Cardinal Glennon Children's Hospital in St. Louis, MO. I also submitted a declaration by Angela Clemente, a forensic analyst and expert in cases involving declarations of brain death. Ms. Clemente has developed a home care plan for Israel in New Jersey in conjunction with a team of medical specialists. Finally, I submitted an email by Dr. Philip DeFina of the International Brain Research Foundation stating that he has a neurologist who will provide treatment and intervention for Israel in New Jersey.

11. Judge Jones issued an order to provide Ms. Fonseca with a "reasonably brief accommodation period" pursuant to CA Health and Safety Code section 1254.4 and set a hearing for April 29, 2016.

12. At the April 29 hearing, Judge Jones dissolved the TRO and dismissed the matter. Judge Jones noted that a separate federal action had been filed. Accompanying this declaration is a copy of the order.

13. Due diligence has been and continues to be pursued to find a California licensed neurologist to examine Israel. Discussions with physicians and hospitals in order to transfer Israel to another facility are ongoing and continuous.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 2nd day of May, 2016 in Citrus Heights, CA.

S/ Alexandra Snyder
Alexandra Snyder, Declarant

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF PLACER

ISRAEL STINSON by and through JONEE FONSECA, his mother
Petitioner;
v.
UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER-WOMEN AND CHILDREN'S CENTER,
Respondent

Case No.: S-CV-0037673

ORDER OF DISMISSAL

Petitioner and applicant Jonee Fonseca has applied for a temporary restraining order directed to Kaiser Permanente Roseville Medical Center—Women and Children's Center concerning medical care and intervention provided to her son Israel Stinson. TRO proceedings were previously heard April 14, 15, 22 and 27, 2016.

A continued hearing was held April 29, 2016, in Department 43, the Hon. Michael W. Jones, presiding. Ms. Fonseca and Nathaniel Stinson, minor's father, appeared with Alexandra M. Snyder, Esq. Jason J. Curliano, Esq., and Madeline L. Buty, Esq., appeared for Kaiser Foundation Hospitals.

At the prior hearing, the court extended the restraining order to implement the Health and Safety Code section 1254.4 reasonably brief period of accommodation for Israel's family, and found that the extension of orders to April 29, 2016, 9:00 a.m., satisfies the statutory requirement for a reasonably brief accommodation period. The court finds that Health and Safety Code sections 7180 and 7181 have been complied with.

Having considered the argument and representations of counsel, the court orders as follows, and for reasons set forth in the record throughout these proceedings, the court orders as follows:

The temporary restraining order previously issued and most recently extended is dissolved by its own terms and this matter is DISMISSED.

The court notes that a separate federal action has been filed and the parties are pursuing relief there.

IT IS SO ORDERED.

DATED: April 29, 2016

Hon. Michael W. Jones
Judge of the Superior Court

Kevin T. Snider, State Bar No. 170988
Counsel of record
Michael J. Peffer, State Bar. No. 192265
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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: 2:16-CV-00889 DECLARATION OF ALEXANDRA SNYDER REGARDING VIDEO FOOTAGE, PHOTO, AND MOVEMENT EXHIBITED BY ISRAEL STINSON

DECLARATION OF ALEXANDRA SNYDER

I, Alexander Snyder, declare as follows:

I am an attorney admitted to the State Bar of California (SL# 252058), and am not a party to the above-encaptioned case. If called upon, I could and would testify truthfully, as to my own personal knowledge, to the following:

1. On April 24, 2016, Israel's parents contacted me to tell me that Israel had been moving his head, shoulder, and arms. I visited the family in the hospital and at 11:52 pm, I recorded a 2 minute, 7 second video of Israel moving his upper body in response to his mother's voice and touch.

2. On April 26, 2016 at 11:15 pm, I recorded a 2 minute, 39 second video of Israel moving his upper body in response to his mother's voice and touch.

3. On April 28, I visited Israel in the hospital. I approached his bedside and, without touching him, said "Hi Israel." Israel immediately moved his head in response to my voice. The two videos can be accessed at:

https://youtu.be/BhgGSjbb08Y

https://youtu.be/Zk6XvuM_4Uw

4. Also, on April 28, I asked the respiratory therapist if he could tell me how the ventilator works. He showed me the monitor and explained that the ventilator was set at certain number of breaths per minute. At that time, it was set at 15 breaths per minute. The respiratory therapist also explained that if the monitor

were to show a higher number, that would indicate that Israel is taking breaths over or in addition to the ventilator.

5. On April 29, the ventilator was set at 14 breaths per minute. I took a photograph of the ventilator monitor showing the setting at 14 breaths per minute. Shortly afterward, I took another photograph of the monitor showing that Israel was breathing at a rate of 16 breaths per minute. Attached as Exhibit 1 to this declaration is a true and correct copy of the photograph.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 2nd day of May, 2016 in Roseville, CA.

_S/ Alexandra Snyder
Alexandra Snyder, Declarant

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: 2:16-CV-00889 **DECLARATION OF JOHN A. NASH REGARDING THE RELIGIOUS BELIEFS OF ISRAEL'S PARENTS**

DECLARATION OF JOHN A. NASH

I, John A. Nash, declare as follows:

1) I am a Professor of Religious Studies at Beulah University in Atlanta, GA.

2) I have known the Stinson family for many years and am familiar with their deeply held beliefs regarding the end of life.

3) Nate Stinson, Israel's father, and Jonee Fonseca, Israel's mother, are Christians who believe that human life does not end until the heart stops beating.

4) I am a supporter of Nate and Jonee's Judeo-Christian historical right to act according to their beliefs on behalf of their critically ill son.

5) Even though this child may have been pronounced brain dead, the family desires that their son be kept on life support.

6) The Stinson family believes—as I do—that only God can take away life and that once a person receives life-sustaining treatment, it is not ethical to remove that treatment, even when the patient has a poor prognosis.

7) For this reason, I and the Stinson family believe Kaiser hospital will go beyond their authority, should it decide to withdraw life support.

8) The historical and biblical Christian belief is to do all that is humanely possible to support life.

9) Israel Stinson, even if he has suffered a severe brain injury is therefore disabled, is a vital and important part of the Stinson family and surrounding community.

10) I ask that the judge would take Nate and Jonee's deeply held beliefs in the inherent value of all human life into consideration.

11) As a friend of the family and a believer in the Christian principle that all human beings are created in the image of God, with innate value, and that life should be protected to the extent humanely possible.

12) I appeal to the court to give this child a chance to live.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 1st day of May, 2016 in Atlanta, Georgia.

_S/ Professor John A. Nash
John A Nash, Declarant
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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: 2:16-CV-00889 **DECLARATION OF DR. PETER MATHEWS REGARDING RECOMMENDATIONS TO PROVIDE THYROID REPLACEMENT, NUTRITIONAL SUPPORT; AND AVAILABILITY TO EXAMINE ISRAEL STINSON**

DECLARATION OF DR. PETER MATHEWS

I, Peter Mathews, MD declare as follows:

1) I am a licensed physician in the State of California, board certified in Internal medicine and retired since November 2013 after a 30-year career.

2) I have reviewed the publicly available information on Israel's case but am currently in San Diego and not able to examine the patient or medical record at this time.

3) In the initial weeks following April 1 the patient's hypothyroidism was not initially treated. The thyroid replacement can affect mental function in some cases and an additional 2 – 4 weeks of support would allow the ruling out of hypothyroidism as a contributing factor to Israel's CNS dysfunction. According to Dr. Paul Byrne, the family reports increasing responsiveness to his mother's voice and painful stimuli since thyroid replacement was resumed.

4) In addition, the family is requesting better nutrition (enteral nutrition) be instituted for supportive care.

5) Kaiser has reportedly done 2 sets of studies documenting brain death. But given the uncertainty related to the thyroid condition and the family reporting some improvement since thyroid replacement, I think it would be both reasonable and compassionate to provide further life support and enteral nutrition (a feeding gastrostomy) for a period of 30 days.

6) If requested by the family, I would be happy to examine Israel and his medical record after May 4 when I return to Northern California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 30th day of April, 2016.

_S/ Peter Mathews, MD
Peter Mathews, MD, Declarant
nappmm@gmail.com

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KAISER PERMANENTE MEDICAL CENTER
ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, Plaintiff, v. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., and DOES 1 THROUGH 10, INCLUSIVE, Defendants.	Case No: 2:16-CV-00889-KJM-EFB **KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO REQUEST FOR TEMPORARY RESTRAINING ORDER AND FURTHER INJUNCTIVE RELIEF** Date: May 2, 2016 Time: 1:30 p.m. Courtroom: 3 Hon. Kimberly J. Mueller Complaint Filed: April 28, 2016

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I. INTRODUCTION

In the universe of tragedies a parent can experience during their lifetime, perhaps no event is more tragic than the death of a child. Kaiser Roseville (hereinafter the use of "Kaiser Roseville" refers to the specific Kaiser Permanente medical facility where Israel was transferred) and its physicians, nurses and other caregivers understand and sympathize with the severity of the plaintiff Jonee Fonseca's heartbreaking circumstances. However, physicians must make medical determinations of when death occurs. In doing so, they must follow certain procedures and make certain determinations under California Health & Safety Code section 7180 *et seq.* (hereinafter in places referred to as the California Uniform Determination of Death Act or "CUDDA") as passed by the California Legislature. [1]

Following a series of medical events and treatment that occurred outside of Kaiser Roseville at other medical institutions, including a finding of brain death by another hospital, Kaiser Roseville agreed to accept the transfer of Israel from the University of California Davis Medical Center in Sacramento ("UCD Medical Center"). The purpose of the transfer was for Kaiser Roseville to further evaluate Israel and to provide independent confirmation that Israel experienced brain death as defined under CUDDA and the Guidelines for the Determination of Brain Death in Infants and Children (hereinafter referred to as "Guidelines"). [2] On April 8, 2016, prior to the transfer, UCD Medical Center made its own determination that Israel experienced brain death.

CUDDA provides a set of statutory rules created by the California Legislature for determining when an individual is medically deceased. Kaiser Roseville followed the procedures under CUDDA. The issue of whether the rules were correctly followed was fully litigated in Placer County Superior Court. On April 29, 2016, after multiple hearings and providing plaintiff and her legal team with two weeks to gather and present evidence, the trial court ruled there was no evidence the doctors and caregivers at Kaiser Roseville failed to comply with CUDDA and the Guidelines in

[1] The determination of death by neurological criteria, e.g., "brain death", has been determined toconstitute death in all jurisdictions in the United States and in most other developed countries. *See* J.L. Bernat, The Whole-Brain Concept of Death Remains Optimum Public Policy, 34(1) J.L. Med. & Ethics 35-43 (2006); D. Gardner, *et al.*, International Perspective on the Diagnosis of Death, 108 British J. Anesthesia i14-i28 (2012).

[2] See Nakagawa, TA. *Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations –Executive Summary*, Annals of Neurology, 2012, Vol. 71, pp. 573-585.

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determining that Israel had experienced brain death. In fact, the record shows that during the two week period and over the course of multiple court hearings, plaintiff did not present a single live witness, and did not present a physician capable of conducting an independent evaluation of Israel consistent with accepted medical standards.[3] Nor did plaintiff direct the trial court's attention to any mistake or lapse in following accepted medical standards by the doctors at Kaiser Roseville.[4] (*See Dority v. Superior Ct.* (1983) 145 Cal.App.3d 273 [the jurisdiction of a California Superior Court "can be invoked upon a sufficient showing that it is reasonably probable that a mistake has been made in the diagnosis of brain death or where the diagnosis was not made in accord with accepted medical standards."] The trial court's ruling found that "Health and Safety Code sections 7080 and 7181 have been complied with" by Israel's medical providers in concluding that Israel experienced brain death. Plaintiff now seeks further relief on these issues in federal court.

II. ISSUES PRESENTED

Here, plaintiff does not appear to be attempting to relitigate the final determination that was made by the state court on April 29, 2016; namely, that Kaiser Roseville's physicians and caregivers complied with CUDDA and the Guidelines in determining that Israel experienced brain death. Although plaintiff's papers are not a model of clarity, the primary argument is that the United States Constitution, in particular the Free Exercise of Religion Clause of the First Amendment, mandates a religious exemption to the determination of brain death under CUDDA. Although this appears to be an issue of first impression, controlling legal authority analyzing the narrow scope of the free exercise clause as it relates to invalidating a facially neutral state law compels a finding that CUDDA is constitutional on its face and it serves a legitimate government interest in regulating medical treatment and having consistency in the decision as to when individuals in California can be declared

[3] The only "medical" evidence presented by plaintiff in the state court action was in the form of a declaration from Dr. Paul Byrne, a retired pediatrician and neonatologist. This same declaration was submitted by plaintiff as part of the papers she filed in federal court. Dr. Byrne is not licensed to practice in the State of California and he has no specialty in neurology. Additional, his opinions, as expressed in Paragraphs 14 and 15, are really that California law iswrong because he believes there can be no finding of death, including brain death, if a patient still breaths and has a beating heart, even though these functions are being sustained by artificial means like they are in Israel's case.

[4] The record shows that Kaiser Roseville was ready to provide medical privileges at its facility to an appropriately qualified physician identified by plaintiff. The record also shows that KaiserRoseville worked with plaintiff and her attorneys in putting the staffing in place to assist in transferring Israel to a medical facility that agreed to accept Israel. Plaintiff was apparently unable to obtain confirmation from an appropriate medical facility that it would accept Israel.

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legally dead. There is also no violation of plaintiff's or Israel's constitutional right to privacy following a determination by physicians and the court that he experienced brain death. Israel also does not suffer from a "disability" that requires some type of an accommodation by Kaiser Roseville.

III. PROCEDURAL AND FACTUAL HISTORY

A. Chronology of medical treatment

As stated in the Complaint filed in the United States District Court for the Eastern District of California, Israel presented to the emergency room at Mercy Hospital on April 1, 2016. Israel's medical record documents that less than four months prior to this most recent emergency admission, Israel presented to Kaiser Vacaville's Emergency Department with a severe asthma attack. In January 2016, the parents and Child Protective Services were informed that Israel's medical history and the failure to comply with medical recommendations were weakening Israel's lung capacity so much so that Israel might, at some point, not be able to recover from a severe bronchospasm event.

Given the severity of his condition on April 1, 2016, Mercy Hospital transferred Israel to the Pediatric Intensive Care Unit at UCD Medical Center. While undergoing care at UCD Medical Center, Israel suffered a severe bronchospasm, which progressed to a cardiac arrest. While Israel's caregivers struggled to save his life, his lungs were so weak, and his health so poor, that he could not adequately respond to medical treatment. After more than 40 minutes of CPR, UC Davis physicians managed to restore cardio-pulmonary functioning with mechanical support. Given the length of time Israel was without oxygen, UC Davis physicians were concerned the anoxic episode had resulted in brain death. The physicians performed an examination to determine his neurological status. The results were consistent with brain death. In addition, a nuclear medicine flow study showed no evidence of cerebral profusion. Israel could not be saved, despite heroic efforts by his many caregivers at UCD Medical Center.

UC Davis physicians advised Israel's parents they intended to perform a second brain death examination. They explained an unfavorable result in a second brain death examination would result in Israel being declared legally dead. Prior to UC Davis physicians performing a second brain death

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examination, Israel's parents arranged to have him, while on mechanical cardio-pulmonary support, transferred to Kaiser Roseville for a second opinion.

On April 12, 2016, Kaiser Roseville admitted Israel with his parent's consent to perform a second brain death examination. That evening, Kaiser Roseville performed a brain death examination, which included a clinical exam, neurological evaluation and apnea test. The results indicated brain death.[5] On April 14, 2016, the physicians at the hospital performed yet another examination, Israel's third determination for brain death. The third examination once again confirmed brain death. In accordance with well-accepted medical standards, a declaration of death was issued.[6] The family was notified, and the "reasonably brief period of accommodation" under Health and Safety Code section 1254.4, which is intended to allow the family and next of kin time to gather at the patient's bedside, began.

Maintaining Israel's organ functions requires constant monitoring and adjustment to his medications, glucose, salt, water and adrenaline. While this constant monitoring and adjustment may be sufficient to delay (but not prevent) the inevitable decay of his organs' function, it is not possible to replicate all the complex chemical, hormonal and other processes that a live, functioning brain regulates and controls. Through the state action and now the federal case, Kaiser Roseville continues to provide extraordinary efforts to maintain Israel's cardio-pulmonary support, even though there is still no evidence to question the determination of brain death made by physicians at UCD Medical Center and at Kaiser Roseville. As plaintiff's counsel advised the state court on several occasions, plaintiff and the family recognize the efforts that have been taken by Kaiser Roseville in this very difficult situation and they are appreciative of those efforts and the care that has been provided by the doctors and staff at Kaiser Roseville.

B. The filing of the state court action

Shortly after Israel was declared brain dead on April 14, 2016, plaintiff petitioned the

[5] Sedative medication was last administered on April 2, 2016.

[6] Israel met the clinical criteria for brain death as laid out and accepted by the medical community, including the: 1) Pediatric Section of the Society of Critical Care Medicine, Mount Prospect, IL; 2) Section on Critical Care Medicine of the American Academy of Pediatrics, Elk Grove Village, IL; 3) Section on Neurology of the American Academy of Pediatrics, Elk Grove Village, IL; and 4) Child Neurology Society, St. Paul, MN.

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Superior Court in Placer County for a temporary restraining order preventing Kaiser Roseville from withdrawing cardio-pulmonary support. Plaintiff also requested time for an independent neurological exam and requested that Kaiser Roseville maintain the level of care Israel had been receiving prior to being declared dead. The Hon. Alan V. Pineschi granted plaintiff's request for a temporary restraining order and assigned the matter to The Hon. Michael W. Jones for hearing on April 15, 2016. The order required Kaiser Roseville to continue providing cardio-pulmonary support and to continue providing medications currently administered, with necessary adjustments to maintain his condition.

On April 15, 2016, the parties, including plaintiff and Nathaniel Stinson, Israel's father, appeared for the hearing in state court. Plaintiff was represented by Alexandra Snyder. Plaintiff requested a two-week continuance of the temporary restraining order in order to have an independent brain death determination performed. Counsel represented that petitioners were being advised by an out of state physician who would find a physician licensed in California to perform an independent examination. During the proceeding, Kaiser Roseville offered testimony from Dr. Myette, Israel's attending physician. Dr. Myette described Israel's clinical course starting from April 1, 2016. He also explained that a determination of brain death in children is a clinical diagnosis based on the absence of neurologic function. The Guidelines recommend two examinations, including apnea testing, with each examination separated by an observation period.

The neurological examination described by Dr. Myette involves a finding of complete loss of consciousness, vocalization, and volitional activities. The patient must lack evidence of responsiveness with an absence of eye opening or moving in response to noxious stimulant.[7] The examination also assesses for the loss of all brainstem reflexes including: no response by the pupils to light, the absence of movement of bulbar musculature including facial and oropharyngeal muscles, no grimacing or facial movements in response to deep pressure on the condyles and supraorbital ridge, the absence of gag, cough, sucking and rooting reflex, the absence of corneal reflexes, and the

[7] Even in brain death, certain non-purposeful muscular movements may occur. These movements do not negate the diagnosis of brain death. Plaintiff has not identified any California licensed physician who will provide competent medical testimony to the contrary. No such testimony or evidence was provided in the state court case.

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absence of oculovestibular reflexes. The apnea test measures the existence or absence of a patient's breathing drive (the ability to draw a breath) by challenging the respiratory system with CO2.

Taken together, the clinical evaluation, neurological examination and apnea test evaluate for brain death. The neurological examination should be performed by different attending physicians. The apnea test may be performed by the same physician. After listening to Dr. Myette and giving plaintiff the opportunity to present any evidence or testimony in support of her case, neither of which was done, the court issued an order continuing the restraining order for one week to April 22, 2016. The additional time was to provide plaintiff with an opportunity to have an independent examination performed.

On April 22, 2016, the parties appeared for the continued hearing on the temporary restraining order. Plaintiff's counsel advised that the family intended to transfer Israel to Sacred Heart Medical Center in Spokane, Washington. To facilitate the transfer, the parties entered into a detailed stipulation, which the court incorporated into an order. The restraining order and related conditions were to stay in effect until April 27, 2016. The parties agreed and were ordered to work together to facilitate the transfer, which they did. Ultimately, Sacred Heart declined Israel's admission. Israel continued to remain at Kaiser Roseville.

On April 27, 2016, the parties appeared for yet another hearing on the temporary restraining order. Plaintiff's counsel requested a continuance of two more weeks to continue her efforts to find a suitable facility to transfer Israel to and to find a physician who would perform another brain death evaluation. Plaintiff also requested that Kaiser Roseville be ordered to install a percutaneous endoscopic gastrostomy tube or "PEG tube" and a tracheostomy tube, upon the representation that it would help to facilitate transfer to another facility or to home care. Plaintiff only provided declarations from Dr. Byrne (see ft. nt. 3) and a critical care coordinator to support her request for an additional continuance. The court found that plaintiff had failed to present competent medical evidence showing a mistake in the determination of brain death or a failure to use accepted medical standards in making that determination. The court also denied plaintiff's request for an order directing physicians at Kaiser Roseville to insert a PEG tube or a tracheostomy tube. The court

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ordered that the restraining order would remain in effect until April 29, 2016, in order to fulfill Kaiser Roseville's obligation to provide the family with a reasonably brief period of time under Health & Safety Code section 1254.4 to gather at Israel's bedside.

On April 28, 2016, plaintiff filed her lawsuit in federal court with a request for a temporary restraining order. Pursuant to plaintiff's ex parte request, The Hon. Troy Nunley issued a temporary restraining order and set a hearing for May 1, 2016.

On April 29, 2016, the parties appeared in state court once again. At this final hearing, the court dissolved the temporary restraining order issued on April 27, 2016 and ruled that "Health and Safety Code sections 7180 and 7181 have been complied with" by Kaiser Roseville and its physicians. The determination of brain death that was challenged by plaintiff and supported by the state court is the only medical determination of brain death relating to Israel. The determinations made by UCD Medical Center and Kaiser Roseville both still stand. To the extent plaintiff believes the trial court erred in making this determination, the remedy is to take a direct appeal in state court of the trial court's decision. Kaiser Roseville is not aware of any appeal having been filed. Additionally, plaintiff did not make a request of the trial court at the hearing on April 29th that the court stay dissolving its restraining order for a relatively brief period of time so that plaintiff could file an appeal in state court and make a request that the court of appeal keep the restraining order in place until the appeal could be heard on the merits. Nor did they ever present a competent expert to perform another examination.

IV. LEGAL ANALYSIS

A. Plaintiff's claims are not asserted against the right legal party since Kaiser Roseville and Dr. Myette are not state or government actors that have allegedly violated plaintiff's constitutional rights.

Plaintiff only named Kaiser Permanente Medical Center Roseville (which is not a legal entity) and Dr. Michael Myette in her lawsuit.[8] Although plaintiff makes a vague allegation in Paragraph 4 of her complaint that "KPRMC receives funding from the state and federal government

[8] Plaintiff also failed to provide notice to the Attorney General of the State of California, thereby prejudicing the State's right to intervene and defend plaintiff's Constitutional attack on CUDDA. See local rule 132, United State District Court, Eastern District of California; 28 USC section 2403; and Federal Rules of Civil Procedure, rule 5.1

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which is used to directly and indirectly provide healthcare services to individuals including but not limited to Israel Stinson," this general statement does not come close to establishing that Kaiser Roseville is a state or government entity against whom a lawsuit for an alleged violation of plaintiff's or Israel's Constitutional rights can be asserted. With respect to Dr. Myette, there is no allegation that he is a state actor. *See Shaw v. Delta Airlines*, 463 U.S. 85, 96 n.14 (1983); *California Shock Trauma Air Rescue v. State Compensation Insurance Fund*, 636 F.3d 538, 544 (9th Cir. 2011); *New Orleans & Gulf Coast Ry. Co. v. Barrios*, 533 F.3d 321, 330 (5th Cir. 2008); *Colonial Penn Grp., Inc. v. Colonial Deposit Co.*, 834 F.2d 229, 237 (1st Cir.1987) ["Jurisdiction over actions for declarations of pre-emption can logically only be asserted where a state official is the defendant"]; and *Lloyd's Aviation, Inc. v. Center for Environmental Health*, 2011 WL 497866 (E.D. Calif. 2011) [the action alleging a Constitutional violation must be one against state officials and not private parties].

There is no specific or detailed allegation in the Complaint that Kaiser Roseville or Dr. Myette are state actors or that either defendant stands in the shoes of the state for purposes of plaintiff seeking injunctive relief against an alleged violation of plaintiff's constitutional rights or the rights of Israel. As the Supreme Court stated in *Brentwood Academy v. Tennessee Secondary School Athletic Association, et al.*, 531 U.S. 288 (2001):

> If the Fourteenth Amendment is not to be displaced, therefore, its ambit cannot be a simple line between States and people operating outside formally governmental organizations, and the deed of an ostensibly private organization or individual is to be treated sometimes as if a State had caused it to be performed. Thus, we say that state action may be found if, though only if, there is such a "close nexus between the State and the challenged action" that seemingly private behavior "may be fairly treated as that of the State itself.

Citations and quotation marks omitted.

Plaintiff has not pled in her Complaint, nor has she submitted any evidence in support of her request for injunctive relief, to establish that Kaiser Roseville or Dr. Myette are state actors that can be enjoined from allegedly violating plaintiff's or Israel's rights under the Constitution. Without a proper factual or legal basis for invoking federal court jurisdiction on the Constitutional claims,

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plaintiff does not have a basis for arguing that injunctive relief is appropriate in this case. In *Jackson v. East Bay Hospital,* 980 F. Supp. 1341, 1357-58 (N.D. Cal. 1997), the Court held that a private hospital "cannot be deemed a state actor merely because they are recipients of state or federal funding...such as Medicare, Medicaid, or Hill-Burton funds." *See also Taylor v. St. Vincent's Hospital,* 523 F.2d 75, 77 (9th Cir. 1975) [receipt of public funds under the Hill-Burton Act was not proper grounds for finding a private hospital to be a state actor for purposes of 42 U.S.C. section 1983]; *Rendell-Baker v. Kohn,* 457 U.S. 830, 840 (1982) [privately operated school not deemed to be a state actor even though "virtually all of the school's income was derived from government funding"].

B. Plaintiff is unable to establish a substantial likelihood of success on the merits or that there are serious questions going to the merits of her claims.

A plaintiff moving for injunctive relief is required to make a very specific showing in support of the request. Rule 65(b) of the Federal Rules of Civil Procedure governs the issuance of temporary protective orders and injunctive relief. The elements required to obtain a preliminary injunction are well-settled: "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008) (citing *Munaf v. Geren,* 553 U.S. 674, 689-690 (2008); *Amoco Production Co. v. Gambell,* 480 U.S. 531, 542 (1987); *Weinberger v. Romero–Barcelo,* 456 U.S. 305, 311–312 (1982).

A preliminary injunction is an extraordinary remedy never awarded as a matter of right. *Winter, supra* at 555 U.S. at 553 (citing *Munaf,* 553 U.S., at 689-690). In the Ninth Circuit, the "serious questions" prong of the sliding scale test arguably survived the holding in *Winter*. Thus, a preliminary injunction is only appropriate when a plaintiff demonstrates that serious questions going to the merits have been raised and the balance of hardships tips sharply in the plaintiff's favor. *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1134-35 (9th Cir. 2011). The petitioner is required to make a showing on all four prongs. *Id.* at 1135. Here, although the events themselves are

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obviously serious and tragic, plaintiff fails to raise "serious questions" going to the merits of her claims as that term has been legally defined.

1. CUDDA provides a legislatively mandated statutory framework within which physicians in the State of California are required to make determinations regarding whether a patient is legally dead.

Modern medicine and technological advancements have enabled physicians to prolong the organ function even after the brain ceases to function and the patient is clinically and legally dead. *Dority v. Superior Court*, 145 Cal.App.3d 273, 277 (1983). Such circumstances often arise out of tragic events. Health & Safety Code section 7180(a)(2) provides, "An individual who has sustained…irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." Although historically, death has been defined as the cessation of heart and respiratory functions, the California Legislature in enacting CUDDA provided an alternative definition of death as an irreversible cessation of all brain function. See *Barber v. Superior Court,* 147 Cal.App.3d 1006, 1013 (1983). As the court stated in *Barber*, in enacting Health and Safety Code section 7019, the Legislature made a "clear recognition of the fact that the real seat of 'life' is brain function rather than mere metabolic processes which result from respiration and circulation." *Id.* For more than twenty years since the enactment of CUDDA, California hospitals and physicians have been determining death by virtue of irreversible cessation of brain function. This has occurred in countless unfortunate situations involving individuals holding various types and degrees of religious beliefs.

Under well-established medical guidelines, a determination of brain death in children is a clinical diagnosis based on the absence of neurologic function with a known irreversible cause of coma. (*Nakagawa, TA. Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations –Executive Summary*, Annals of Neurology, 2012, Vol. 71, pp. 573-585.) As explained by Dr. Myette in the state court action, the Guidelines recommend two examinations, including apnea testing, with each examination separated by an observation period. *Id.* The neurological examination involves a finding of complete loss of

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consciousness, vocalization, and volitional activities. The patient must lack all evidence of responsiveness with an absence of eye opening or movement in response to noxious stimulant. The examination also assesses for the loss of all brainstem reflexes including: no response by the pupils to light, the absence of movement of bulbar musculature including facial and oropharyngeal muscles, no grimacing or facial movements in response to deep pressure on the condyles and supraorbital ridge, the absence of gag, cough, sucking and rooting reflex, the absence of corneal reflexes, and the absence of oculovestibular reflexes. The apnea test measures the existence or absence of a patient's breathing drive (the ability to draw a breath) by challenging the respiratory system with CO2. Taken together, the clinical evaluation, neurological examination and apnea test evaluate for brain death. The neurological examination should be performed by different attending physicians. *Id.* The apnea test may be performed by the same physician. *Id.* Unfortunately, the unrefuted medical evidence in the case establishes that Israel meets the aforementioned criteria for brain death.

Both UCD Medical Center and Kaiser Roseville followed the well-established examination protocol to determine brain death. All results were consistent with brain death. In addition, a nuclear medicine radionuclide scan revealed no profusion in Israel's brain. MRI and CT scans of Israel's head showed a herniated brain stem. Kaiser Roseville performed the brain death examination twice. The second examination at Kaiser Roseville was administered after an appropriate waiting period and by a different attending physician. Each physician conducted the examinations in full compliance with the Guidelines on brain death examinations.

Health & Safety Code section 7181provides, "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician." In most cases, a different physician from the same treating facility provides the independent confirmation. Here, Israel suffered his anoxic event on April 2, 2016. His first brain death examination occurred on April 8, 2016 at UCD Medical Center. A second brain death examination occurred on April 12, 2016 at Kaiser Roseville. A third brain death examination occurred at Kaiser Roseville on April 14, 2016. Three different physicians have administered brain death examinations

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and each found the results to be consistent with brain death. Other tests, such as MRI/CT scans and nuclear medicine radionuclide scans corroborate the finding of brain death. Neither the results of the tests nor the manner in which they were conducted have been challenged by plaintiff. The state court found the examinations complied with CUDDA.

This is not a situation involving a person in a persistent vegetative state, where the person is in an unconscious wakeful state with a diminished level of brain activity. Rather, Israel's brain has permanently and completely stopped functioning. When a person in a persistent vegetative state is on cardio-pulmonary support, the patient's maintenance requires keeping a relatively stable individual on a machine and checking the patient's vital signs. Because Israel's brain is no longer communicating to his organs or functioning at all, many metabolic functions and chemical processes will not occur without mechanical support and will degrade over time. Maintaining support to Israel's organs requires constant monitoring and adjustments to his glucose, salt, medication, adrenaline and other hormone levels. Continued cardio-pulmonary support, medication and nutrition is a futile effort. Israel's condition cannot and will not improve over time, because he has suffered permanent, irreversible and total cessation of all brain functions. While the death of a child is always tragic, futile care deprives Israel the dignity of his death.

2. Kaiser Roseville provided plaintiff and Israel's family with a period of time to accommodate the religious practices and concerns of plaintiff and her family.

Kaiser Roseville has been sensitive to the concerns raised by plaintiff. It provided plaintiff with a reasonable period of time to make arrangements for Israel which could have included transferring him to another medical facility, even though a determination was made by physicians at both Kaiser Roseville and UCD Medical Center that Israel was unfortunately brain dead. The state court supervised the timing and allowed plaintiff the additional time that the court felt was reasonable under the circumstances. Health & Safety Code section 1254.4, which became law on January 1, 2009, requires a hospital covered by CUDDA to provide a "reasonably brief period" of time for the parents and family to gather at the patient's bedside. *Id.* It also requires a covered hospital to make "reasonable efforts to accommodate those religious and cultural practices and

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concerns" expressed by the parents and family. In determining what is "reasonable" a hospital "shall consider the needs of other patients and prospective patients in urgent need of care." *Id.* The state court found that Kaiser Roseville had satisfied this statutory requirement to provide a reasonably brief period of accommodation.

3. Kaiser Roseville physicians have provided appropriate care to Israel and this care should not include placement of a PEG tube or a tracheostomy tube.

a. The state court has already ruled that Kaiser Roseville physicians cannot be directed to place a PEG tube or a tracheostomy tube.

Plaintiff suggests in her Complaint and declarations filed in federal court that Kaiser Roseville is required to accommodate plaintiff by conducting medical procedures its physicians believe, in the exercise of their clinical judgment would be medically futile, given the finding of brain death. Plaintiff also asserts that Kaiser Roseville physicians are required to indefinitely keep Israel on artificial physiological support until he can be transferred, or until the condition of his body deteriorates to the point where it meets plaintiff's definition of death, e.g., when the heart goes into cardiac arrest and breathing can no longer be artificially maintained. The trial court specifically ruled that requiring Kaiser Roseville doctors to conduct these procedures would create significant ethical concerns. Plaintiff should not be permitted to relitigate this issue in her federal court case.

Plaintiff is now making the same request in a different forum. Plaintiff made this request in state court and Judge Jones denied her request, finding Health & Safety Code section 1254.4, did not require Kaiser to provide any additional medical care. Collateral estoppel precludes relitigation of issues argued and necessarily decided in prior proceedings. *Ivanova v. Columbia Pictures Industries, Inc.* 217 F.R.D. 501 (2003). Federal courts must accord a state court judgment or determination the same preclusive effect that the judgment or determination would receive in the rendering state's courts. *Skysign Int'l, Inc. v. City & Cty. of Honolulu*, 276 F.3d 1109, 1115 (9th Cir. 2002) (citing 28 U.S.C. section 1738). In *Lucido v. Sup. Ct.* (1990) 51 Cal.3d. 335, 341-43, the California Supreme Court articulated six criteria required for the application of issue preclusion: (1) the issue "must be identical to that decided in a former proceeding"; (2) it "must have been actually litigated in the

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former proceeding"; (3) it "must have been necessarily decided in the former proceeding"; (4) "the decision in the former proceeding must be final and on the merits"; (5) "the party against whom preclusion is sought must be the same as, or in privity with, the party to the former proceeding"; and (6) application of issue preclusion must be consistent with the public policies of "preservation of the integrity of the judicial system, promotion of judicial economy, and protection of litigants from harassment by vexatious litigation." Here, the criteria for issue preclusion are met. Plaintiff sought the same injunctive relief in the state court proceeding. She provided declarations supporting the placement of a PEG tube and tracheostomy tube. Judge Jones considered her request and expressly denied the relief sought. By dissolving the temporary restraining order, Judge Jones' decision became final. The parties are the same and the application of issue preclusion is consistent with the public policy of preventing an unsuccessful litigant from "shopping around" for relief after an unfavorable decision. See *B & B Hardware, Inc. v. Gargis Industries, Inc.*, 135 S.Ct. 1293, 1299 (2015).

b. Under California law physicians are not required to participate in medical procedures they believe would not improve the condition of the patient.

Plaintiff provided no legal support in the state court action, nor has she provided any in her moving papers in this case, to support a request to have physicians perform invasive medical procedures on Israel who has been declared legally dead. There is nothing in the language of Health & Safety Code section 1254.4 that requires this to be done. California has enacted a fairly detailed statutory framework governing when a physician may refuse to provide medical care that the physician believes would not improve the condition of the patient. Probate Code section 4735 provides "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." In addition, Probate Code section 4654 states, "This division does not authorize or require a health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution."

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Finally, Probate Code section 4736 provides guidelines for the transfer of a patient with respect to pain medication and palliative care.

In *Barber v. Superior Court*, *supra* 147 Cal.App.3d at 1018, a criminal case against two physicians, the court affirmed the general principle that a physician has no duty to continue treatment that is ineffective:

> A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless.... If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery. (Horan, Euthanasia and Brain Death: Ethical and Legal Considerations (1978) 315 Annals N.Y.Acad. **217 Sci. 363, 367, as quoted in President's Commission, supra, ch. 5, p. 191, fn. 50.)

In this case, although plaintiff honestly believes placement of a PEG tube and tracheostomy tube will improve Israel's condition, no competent medical testimony has been presented by plaintiff to support this belief. Unfortunately, Israel has been determined to be brain dead. This determination was made first by physicians at UCD Medical Center on April 8th and again by physicians at Kaiser Roseville back on April 14th. Dr. Myette testified in state court that the physical damage done to Israel before he presented to Kaiser Roseville is irreversible. There is nothing medicine can do to change this unfortunate fact.

4. Plaintiff's claim alleging a violation of the Free Exercise Clause of the First Amendment of the United States Constitution is not substantially likely to succeed and it does not raise a serious questions going to the merits.

The Free Exercise Clause of the First Amendment provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof...." United States Constitution, Amendment I. The Free Exercise Clause is applicable to the States by its incorporation into the Fourteenth Amendment. *Cantwell v. Connecticut,* 310 U.S. 296, 303 (1940). Despite the broad language of the Constitution, the right to exercise one's religion freely is not unlimited. In *Emp't Div., Dep't of Human Res. Of Ore. v. Smith*, 494 U.S. 872, 879 (1990), the Supreme Court

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explained the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the grounds that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes). *Smith*, 494 U.S. at 879. Additionally, the state enacting the law that is being challenged is not required by the Constitution to create a religious practice exemption. *Smith, supra* at 890; *A Woman's Friend Pregnancy Resource Center v. Attorney General of the State of California*, 2015 WL 9274116 (E.D. Calif. 2015), citing to and relying on *Smith.*

When a challenged law is neutral on its face, as it is in this case, the question for the court is whether it can survive a rational basis standard of review. *Stormans, Inc. v. Weisman*, 794 F.3d 1064, 1075-76 (9th Cir.2015). The law must be upheld if it is rationally related to a legitimate governmental purpose. *Id.* at 1084, citing *Gadda v. State Bar. Of Cal.* 511 F.3d 933, 938 (9th Cir.2007). In challenging the law and whether a rational basis exists, plaintiff has the "burden to negat[e] every conceivable basis which might support [the rules]. *Id.*, *quoting FCC v. Beach Commc'ns. Inc.*, 508 U.S. 307, 315 (1993). Additionally, because plaintiff is seeking injunctive relief, plaintiff must demonstrate that the balance of hardships tips "sharply" in her favor, as well as the likelihood of irreparable injury and that the injunction is in the public interest. *Alliance for the Wild Rockies v. Cottrell, supra* at 1134-35 (9th Cir. 2011).

California has a rational basis for defining when death occurs. *In re Christopher*, 106 Cal.App.4th 533, 550 (2003) ["The California Legislature has recognized that medical technology may prolong the process of dying and that continued health care that does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person."]; *Dority, supra* 145 Cal.App.3d 273. In *Dority*, a guardian was appointed to make medical decisions for a 19 day old infant after the parents were placed in custody for child abuse. After conducting an appropriate medical examination under Health & Safety Code section 7180, *et seq.*, the attending doctors concluded the infant was brain dead as that term is defined under California law. The guardian appointed by the court became involved to decide whether the child should be removed from life support. After a hearing at which

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unrefuted medical testimony established the infant was brain dead, the court directed the guardian to authorize the removal of all artificial support being provided to the infant. The parents objected to consent being given. Although the court of appeal was unable to rule on the legal issues before the infant passed away, the court determined that important public policy issues raised in the case warranted a decision even after the infant had passed.

The Court in *Dority* discussed the competing interests in determining whether or not life support should be removed when a child is declared brain dead, as well as the question of what safeguards are in place to have this decision reviewed by the courts. The court in *Dority* stated:

> Many times prolonging this biological existence with life-support devices only prolongs suffering, adding economical and emotional burden to all concerned. Conversely, a decision to withdraw these devices which would eventually result in the cessation of all bodily functions even though no life is left may cause equal emotional trauma.

The court went on to acknowledge the need in situations like this for the doctors and hospital to involve the parents in the process. *Id.* at 279. However, where there is a disagreement over the medical determination of brain death in a child, "the jurisdiction of the court can be involved upon a sufficient showing that it is reasonably probable that a mistake has been made in the diagnosis of brain death or where the diagnosis was not made in accord with accepted medical standards." *Id.* at 280. The Court then went on to hold that given the competing interests and rights of the parties and after hearing unrefuted medical testimony that the infant was brain dead, including testimony from the medical providers, it was within the court's power to find the infant had been determined to be brain dead and that artificial support was appropriately ordered by the trial court to be removed. *Id.* at 280. The decision made by the Court in *Dority* is the same decision that was made by the state court in this case.

The California Legislature, along with the overwhelming majority of other states (see ft. nt.1), have made a determination that irreversible cessation of all functions of the brain, including the brain stem, constitutes death in the eyes of the law. Health & Safety Code section 7180(a)(2). There is a rational basis for the Legislature's decision to so define death. See Probate Code sections 4654, 4735, 4736; *Barber, supra,* at 147 Cal.App.3d 1983; *Dority, supra,* at 145 Cal.App.3d 273;

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and *In re Christopher, supra,* at 106 Cal.App.4th 533. Plaintiff will be unable to meet her "burden to negat[e] every conceivable basis which might support [the rules]." *Stormans, supra,* at 1075-76.

The legal definition of brain death under CUDDA aligns with the medical reality that the brain is the orchestrator of all other bodily functions, such that an inert brain can no longer sustain life nor be considered itself to be alive. The law also recognizes that modern medical technology can artificially maintain organ function and bodily activities even in a person who has no hope of ever regaining the ability to perform any of these things on their own. As applied to health care providers, an expectation that such persons be deemed alive places ethical burdens on individuals whose mission is to heal, treat pain, and assist people in giving birth and ending life, not to mention the resource strain such an expectation would impose on the health care system.

5. Plaintiff's claim alleging a violation of her Right to Privacy under the Fourth and Fourteenth Amendments to the United States Constitution is not substantially likely to succeed and it does not raise a serious questions going to the merits.

With respect to both plaintiff's Third and Fourth Count in her Complaint, plaintiff alleges on her behalf and on behalf of Israel that their "right to privacy" was denied by defendants. See Complaint, pg. 12:5-10 and pg. 13:17-22. There is no statement by plaintiff regarding the healthcare that is allegedly being denied or how a privacy interest is being denied with respect to making decisions for Israel. A medical determination has been made that Israel is brain dead. Plaintiff sought review of this decision in state court where the determination made by both UCD Medical Center and Kaiser Roseville was affirmed.

To the extent plaintiff's allegations are raising a claim of a denial of substantive due process, the Supreme Court "require[s] in substantive due-process cases a 'careful description' of the asserted fundamental liberty interest." *Washington v. Glucksberg*, 521 U.S. 01, 728 (1997). The substantive due process right being asserted by plaintiff "must be carefully stated and narrowly identified before the ensuing analysis can proceed." *Raich v. Gonzales*, 500 F3d 850, 864 (9th Cir.2007). If plaintiff is alleging that she has a substantive due process right to redefine the definition of brain death that has been established by the California Legislature under CUDDA, she

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has provided absolutely no citation to controlling or even instructive legal authority, nor is there any legal analysis in her ex-parte papers. Moreover, Dr. Myette and Kaiser Roseville are not the proper parties to this case since they both simply followed the mandatory statutory rules promulgated by the California Legislature. Plaintiff's issues are with the Legislature and its enactment of CUDDA.

Plaintiff has failed to clearly define what substantive right she is asking the court to find is protected by her right to privacy or any right to privacy that may be held by Israel. The Supreme Court has cautioned that restraint should be exercised in finding substantive due process rights "because guideposts for responsible decision making in this uncharted area are scarce and open-ended" and because judicial extension of constitutional protection for an asserted substantive due process right "place[s] the matter outside the arena of public debate and legislative action" (citations omitted)); *Glucksberg*, *supra*, 521 U.S. at 720; *Reno v. Flores*, 507 U.S. 292, 302 (1993) (noting that "[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field" (quoting *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992).

6. There is no basis for asserting a claim under the Rehabilitation Act and the ADA under the facts alleged in this case.

It is not at all clear how plaintiff can assert claims under the Americans with Disability Act ("ADA") as embodied in 42 U.S.C. section 12101 *et seq.* or the Federal Rehabilitation Act as embodied in 29 U.S.C. section 794 *et seq*. See *Thompson v. Davis*, 295 F.3d 890, 895 (9th Cir.2002) discussing factors needed to assert an ADA claim.

7. The abstention doctrine under Colorado River v. United States should result in the staying of any federal court proceedings until the state court proceedings are concluded.

On April 29, 2016, the state court issued its final ruling. Plaintiff has a right to appeal that ruling in state court. During the hearing on April 29th plaintiff did not make a request that the trial court stay its order dissolving the temporary restraining order until a notice of appeal could be filed the following week. That appeal would involve the issues decided by the state court concerning state law; specifically California's adoption and implementation of CUDDA, and whether there

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should be a religious exemption to the definition of brain death under CUDDA. Plaintiff now seeks an adjudication of those issues in federal court instead of utilizing the proper state appellate process. When an issue or claim is raised in a federal court case that is also the subject of a state court proceeding, federal courts should abstain from adjudicating the issues that are pending in state court. *Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 817 (1976). Plaintiff's Complaint only seeks declaratory relief. There is no claim being made for damages. Following the doctrine of abstention is particularly appropriate when (1) the issue raised is one of state law, (2) the state court case is more developed than the case in federal court, and (3) the federal court case seeks declaratory relief on the issues that are pending in state court. *Id.* at 818; *R.R. Street & Co. v. Transport Ins. Co.*, 656 F3d 966, 980-981 (9th Cir.2011); *Snodgrass v. Provident Life & Accident Ins. Co.*, 147 F.3d 1163, 1167-1168 (9th Cir.1988). Accordingly, to the extent this court is inclined to adjudicate the issues and claim for relief in plaintiff's Complaint, the court should stay the proceeding and abstain from taking any further action while plaintiff prosecutes her right to an appeal in state court.

V. CONCLUSION

For all the foregoing reasons, Kaiser Roseville and Dr. Myette believe the requested injunctive relief should be denied in its entirety.

DATED: May 1, 2016

BUTY & CURLIANO LLP

By: _____
JASON J. CURLIANO
Attorneys for Defendants
KAISER PERMANENTE MEDICAL CENTER ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

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PROOF OF SERVICE

I am employed in the County of Alameda, State of California. I am over the age of eighteen years and not a party to the within entitled cause; my business address is 516 16th Street, Oakland, CA 94612.

On May 1, 2016, I caused to be served the following document:

KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO REQUEST FOR TEMPORARY RESTRAINING ORDER AND FURTHER INJUNCTIVE RELIEF

on the interested parties in said cause, by: placing a true copy thereof enclosed in a sealed envelope addressed as follows and I caused delivery to be made by the mode of service indicated below:

Kevin T. Snider, State Bar No. 170988
Michael J. Peffer, State Bar. No. 192265
Matthew B. McReynolds, State Bar No. 234797
PACIFIC JUSTICE INSTITUTE
P.O. Box 276600
Sacramento, CA 95827
Tel. (916) 857-6900
Fax (916) 857-6902
Email: ksnider@pji.org

X I caused a true and correct copy of the aforementioned document(s) to be transmitted electronically to all parties designated on the United States Eastern District Court CM/ECF website.

___ (By Mail) on all parties in said action in accordance with Code of Civil Procedure Section 1013, by placing a true and correct copy thereof enclosed in a sealed envelope in a designated area for outgoing mail, addressed as set forth above, at Buty & Curliano, which mail placed in that designated area is given the correct amount of postage and is deposited that same day, in the ordinary course of business, in a United States mailbox in the County of Alameda.

____ (By Email): On May 1, 2016 I caused a copy of the document(s) described on the attached document list, together with a copy of this declaration, to be emailed listed on the attached service list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 1, 2016, at Oakland, California.

Susan Truax

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Attorneys for Defendants:
KAISER PERMANENTE MEDICAL CENTER
ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., and DOES 1 THROUGH 10, INCLUSIVE,

Defendants.

Case No: 2:16-CV-00889-KJM-EFB

DECLARATION OF JASON J. CURLIANO IN SUPPORT OF KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO REQUEST FOR TEMPORARY RESTRAINING ORDER AND FURTHER INJUNCTIVE RELIEF

Date: May 2, 2016
Time: 1:30 p.m.
Courtroom: 3
Hon. Kimberly J. Mueller

Complaint Filed: April 28, 2016

I, Jason J. Curliano, hereby declare:

1. I am an attorney at law licensed to practice in the courts of the State of California, including the United States District Court for the Eastern District of California, and am a partner with Buty & Curliano LLP, attorneys of record for defendants KAISER PERMANENTE MEDICAL CENTER ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

("Defendants"). All the facts stated herein are within my personal knowledge and if called as a witness, I could competently testify thereto.

2. Attached hereto as Exhibit A is a true and correct copy of Plaintiff's Verified Ex-Parte Petition for Temporary Restraining Order/Injunction; Request for Order of Indendent (*sic.*) Neurological Exam; Request for Order to Maintin (*sic.*) Level of Medical Care.

3. Attached hereto as Exhibit B is a true and correct copy of Judge Pineschi's Order on Ex Parte Application for Temporary Restraining Order.

4. Attached hereto as Exhibit C is a true and correct copy of the Reporter's Transcript of Petition Hearing dated April 15, 2016 regarding Plaintiff's state court petition.

5. Attached hereto as Exhibit D is a true and correct copy of Judge Jones' Order on Ex Parte Application for Temporary Restraining Order dated April 15, 2016.

6. Attached hereto as Exhibit E is a true and correct copy of the Reporter's Transcript of Petition Hearing dated April 22, 2016.

7. Attached hereto as Exhibit F is a true and correct copy of Judge Jones' April 22, 2016 Order.

8. Attached hereto as Exhibit G is a true and correct copy of the Reporter's Transcript of Petition Hearing dated April 27, 2016,

9. Attached hereto as Exhibit H is a true and correct copy the Declaration of Dr. Paul Byrne offer by Plaintiff at the April 27, 2016 hearing.

10. Attached hereto as Exhibit I is a true and correct copy of the Declaration of Angela Clemente offered by Plaintiff at the April 27, 2016 hearing.

11. Attached hereto as Exhibit J is a true and correct copy of Judge Jones' April 27, 2016 order.

12. Attached hereto as Exhibit K is a true and correct copy of the Reporter's Transcript of Petition Hearing dated April 29, 2016.

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13. Attached hereto as Exhibit L is a true and correct copy of Nakagawa, TA. *Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations –Executive Summary*, Annals of Neurology, 2012, Vol. 71.

14. Attached hereto as Exhibit M is a true and correct copy of J.L. Bernat, *The Whole-Brain Concept of Death Remains Optimum Public Policy*, 34(1) J.L. Med. & Ethics 35-43 (2006).

15. Attached hereto and Exhibit N is a true and correct copy of D. Gardner, *et al.*, *International Perspective on the Diagnosis of Death*, 108 British J. Anesthesia i14-i28 (2012).

I declare under penalty of perjury that the foregoing is true and correct. Executed on May 1, 2016, in Oakland, California.

JASON J. CURLIANO

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PROOF OF SERVICE

I am employed in the County of Alameda, State of California. I am over the age of eighteen years and not a party to the within entitled cause; my business address is 516 16th Street, Oakland, CA 94612.

On May 1, 2016, I caused to be served the following document:

DECLARATION OF JASON J. CURLIANO IN SUPPORT OF KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO REQUEST FOR TEMPORARY RESTRAINING ORDER AND FURTHER INJUNCTIVE RELIEF

on the interested parties in said cause, by: placing a true copy thereof enclosed in a sealed envelope addressed as follows and I caused delivery to be made by the mode of service indicated below:

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Susan Truax

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EXHIBIT A

709

Jonee Fonseca
Mother of Israel Stinson
Address

Telephone withheld for privacy but
provided to Court and Respondent

IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

UNLIMITED CIVIL JURISDICTION

Israel Stinson, a minor, by Jonee Fonseca his mother.

Petitioner,

v.

UC Davis Children's Hospital; Kaiser Permanente Roseville Medical Center – Women and Children's Center.

Respondent.

Case No. SCV0037673

VERIFIED EX-PARTE PETITION FOR TEMPORARY RESTRAINING ORDER/INJUNCTION; REQUEST FOR ORDER OF INDENDENT NEUROLOGICAL EXAM; REQUEST FOR ORDER TO MAINTIN LEVEL OF MEDICAL CARE

I Jonee Fonseca am the mother of Israel Stinson who, on April 1, 2016 went to Mercy Hospital with symptoms of an asthma attack. The Emergency room examined him, placed him on a breathing machine, and he underwent x-rays. Shortly thereafter he began shivering, his lips turned purple, eyes rolled back and lost csoncswiu0osness,. He had an intubation performe don him. Doctor told me they had to transcer Israel to UC Davis because they did not have a pediatric unit. HE was then taken to UC Davis via ambulance and admitted to the pediatric intensive care

unit. The next day, the tube was removed from Israel. The respiratory therapist said that Israel was stable and that they could possibly discharge him the following day, Sunday April 3. They put him on albuterol for one hour, and then wanted to take him off albuterol for an hour. About 30 minutes in, I noticed that he began to wheeze and have issues breathing. The nurse came back in and put him on the albuterol machine. Within a few minutes the monitor started beeping. The nurse came in and repositioned the mask on Israel, then left the room.

Within minutes, he started to shiver and went limp in her arms. I pressed the nurses' button, and screamed for help, but no one came to the room. A different nurse came in, and I asked to see a doctor. The doctor, Dr. Meteev came to the room and said she did not want to intubate Israel to see if he could breathe on his own without the tube.

Israel was not breathing on his own. I had to leave the room to compose myself. When I came back five minutes later, the doctors were performing CPR. The doctors dismissed me from the room again while they performed CPR for the next forty (40) minutes.

Dr. Meteev told me that Israel was going to make it and that he would be put on an ECMO to support his heath and lungs. Dr. Meteev also told me that Israel might have a blockage in his right lung because he was not able to receive any oxygen. A pulmonologist checked Israel's right lung, and he did not have any blockage.

Dr. Meteev then indicated that there was a possibility Israel will have brain damage. HE was sedated twice due to this blood pressure being high, and was placed on an ECMO machine and ventilator machine.

On Sunday April 3, 2016, A brain test was conducted on Israel to determine possibility of brain damage while he was hooked up to the ECMO machine. The test involved poking his eye with a Q-tip, banging on his knee, flashing a light in his eye, flushing water down his ear, and

putting a stick down his throat to check his gag reflexes. On April 4, 2016, the same tests were performed when he was taken of the ECMO machine. On April 6, 2016 he was taken off the ECMO machine because his hearth and lungs were functioning on their own. However, the next day, a radioactive test was performed to determine blood flow to the brain.

I begged for an MRI and CT scan to be done on Israel before the third and final doctor performed the test. This was done on April 10, 2016. These results still have not been given to me, and I've been told that the results are only "preliminary."

On April 11, 2016, Israel was transferred via ambulance to Kaiser Hospital in Rosveille. That night, another reflex test was done, in addition to an apnea test. Then, on April 14, 2016, an additional reflex test was done.

I am a Christian and believe in the healing power of God. I do not want him pulled off life support. Kaiser has said that they have the right to remove Israel from life support ~~on~~ this afternoon (4.19.16)

I am hereby asking that Kaiser Permanente Roseville Medical Center be prevented from removing my son, Israel Stinson, from his ventilator.

If Kaiser removes Israel from a respirator and he stops breathing then they will have ended his life as well as their responsibility to provide his future care for the harm their negligence caused. For this reason we hereby request that an independent examination be performed, including the use of an EEG and a cerebral blood flow study. I also request that Kaiser Permanente Roseville Medical Center be ordered to continue to provide such care and treatment to Israel that is necessary to maintain his physical health and promote any opportunity for healing and recovery of his brain and body. Failure to issue the Restraining Order will result in irreversible and irreparable harm so a basis in both law and fact exists for this court's intervention.

LEGAL ARGUMENT

California Health and Safety Code Section 7180 (a) (The Uniform Determination of Death Act) provides for a legal determination of brain death as follows; "(a) An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2), irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

Health and Safety Code Section 7181 provides for an "independent" verification of any such determination stating; "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be ***independent confirmation*** by another physician."

As established by the Court in Dority v Superior Court (1983) 145 Cal.App.3d 273, 278, this Court has jurisdiction over the issue of whether a person is "brain dead" or not pursuant to Health and Safety Code Sections 7180 & 7181. Acknowledging the moral and religious implications of such a diagnosis and conclusion, the *Dority* court determined that it would be "unwise" to deny courts the authority to make such a determination when circumstances warranted.

Here only doctors from Anaheim Regional Medical Center have examined Kalea Roseville Forcel. As stated above, I do not trust them to be independent given how they are responsible for her current condition and they have a conflict of interest in determining her condition; if she is disconnected and dead, they no longer have to pay for any of her care, if she is severely brain damaged, but not brain dead, they may be legally liable to provide her ongoing care and treatment at Anaheim Regional or elsewhere.

Only one other case of this type is on record in California namely the case of Jahi McMath which was heard in Alameda County in December of 2013. That case, one of first impression, where Nailah Winkfield challenged Children's Hospital Oakland's determination of brain death after they negligently treated her daughter, Jahi, led to an Order, issued by Hon E. Grillo, holding that an independent determination is one which is performed by a physician with no affiliation with the hospital facility (in that case Children's Hospital Oakland) which was believed to have committed the malpractice which led to the debilitating brain injuries Jahi suffered. A true and correct copy of Judge Grillo's Order is attached to this Petition. In the *McMath* case, the Trial Court rejected the Hospital's position that the Court had no jurisdiction over the determination of whether not Jahi McMath was "brain dead" or not.

In *McMath*, Judge Grillo stated that the Section 7180's language regarding "accepted medical standards" permitted an inquiry into whether the second physician (also affiliated with Children's Hospital Oakland) was "independent" as that term was defined under Section 7181. Judge Grillo determined that the petitioner's due process rights would be protected by a focused proceeding providing limited discovery and the right to the presentation of evidence. The Court determined that, under circumstances which are strikingly similar to those which present themselves here, the conflict presented was such that the court found that the Petitioner was entitled to have an independent physician, unaffiliated with Children's Hospital Oakland, preform neurological testing, an EEG and a cerebral blood flow study. Indeed, the Court Ordered Children's Hospital Oakland to permit the Court's own court appointed expert to be given temporary privileges and access to the Hospital's facilities, diagnostic equipment, and technicians necessary to perform an "independent" exam.

As in *Dority* and *McMath*, the unique circumstances of this case invoke the Court's jurisdiction and due process considerations require that this Court grant Petitioner's Petition for a Temporary Restraining Order and order that Anaheim Regional Medical Center permit Petitioner to obtain an independent medical examination at Anaheim Regional Medical Center with the assistance of The Medical Center's diagnostic equipment and technicians necessary to carry out the standard neurologic brain death examination with a repeat EEG and a Cerebral Blood Flow Study.

In order to provide the requisite physical conditions for a reliable set of tests to be performed, Israel Avila should continue to be treated so as to provide his optimum physical health and in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics).

WHEREFORE, petitioner prays:

1) That a Temporary Restraining Order precluding Respondents from removing Israel Stinson from respiratory support, or removing or withholding medical treatment be issued;

2) That an Order be issued that Respondents are to continue to provide Israel Stinson treatment to maintain his optimum physical health and in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics in such a manner and/or at such time that they may interfere with the accuracy of the results).

3) That an Order be issued that Petitioner is entitled to an independent neurological examination, with the assistance of Kaiser Permanente Roseville Medical Center's diagnostic equipment and technicians necessary to carry out the standard neurologic brain death examination with a repeat EEG and a Cerebral Blood Flow Study.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on April 14, 2016, at Roseville, California.

Jonee Fonseca

Jonee Fonseca

Jonee Fonseca
Mother of Israel Stinson
Address

Telephone withheld for privacy but
provided to Court and Respondent

IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

UNLIMITED CIVIL JURISDICTION

SCV0037673

Israel Stinson, a minor, by Jonee Fonseca his mother.

Petitioner,

v.

UC Davis Children's Hospital; Kaiser Permanente Roseville Medical Center – Women and Children's Center.

Respondent.

Case No.
[PROPOSED] ORDER OR TEMPORARY RESTRAINING ORDER/INJUNCTION: REQUEST FOR ORDER OF INDENDENT NEUROLOGICAL EXAM; REQUEST OF ORDER TO MAINTIN LEVEL OF MEDICAL CARE

RECEIVED
APR 14 2016
Superior Court of California
County of Placer

The Verified Petition of Jonee Fonseca for a temporary restraining order came before the Court upon ex-parte application at _____ in Department ____ of the Placer County Superior Court, the Hon. _____ presiding.

After considering the Petition the Court finds that:

1) There is a basis in law and in fact for the issuance of a temporary restraining order;

2) Failure to grant the petition will potentially result in irreparable harm to the patient Israel Stinson and this Order is necessary until such time that the Petitioner can obtain

her son's medical records and obtain an independent medical examination and the court, if needed, can hold further evidentiary hearing.

THEREFORE IT IS ORDERED THAT:

The temporary restraining order is hereby granted precluding the respondent from removing Israel Stinson from the ventilator or ending any of the current treatment and support provided by Respondent and that Respondent shall continue to treat Israel Stinson in such a manner so as to optimize his physical health and provide optimum conditions for further independent neurological examination.

This Temporary Restraining Oder Orders the following:

1) Respondents are restrained from removing Israel Stinson from respiratory support, or removing or withholding medical treatment be issued;

2) Respondents are to continue to provide Israel Stinson treatment to maintain her optimum physical health and in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics in such a manner and/or at such time that they may interfere with the accuracy of the results).

3) That Petitioner is entitled to an independent neurological examination, with the assistance of Kaiser Permanente Roseville Medical Center's diagnostic equipment and technicians necessary to carry out the standard neurologic brain death examination with a repeat EEG and a Cerebral Blood Flow Study.

4) That Petitioner immediately serve a copy of its Petition and this Order upon the Chief Medical Officer and/or Legal Department.

5) That the matter is set for further hearing at ____ o'clock a.m./p.m. on the ____ day of _____, 2016 in Dept. _____ of the Placer County Superior Court for a Status Conference and, if necessary, setting conference where the schedule for discovery and further hearing upon the matter, if any, will be set.

Dated: April ___, 2016

_____

Hon.
Judge of the Superior Court

EXHIBIT B

FILED
Superior Court of California
County of Placer
APR 14 2016
Jake Chatters
Executive Officer & Clerk
By K. Zaragoza, Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF PLACER

ISRAEL STINSON by and through JONEE FONSECA, his other
Petitioner;
v.
UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER-WOMEN AND CHILDREN'S CENTER,
Defendants

Case No.: S-CV-0037673

ORDER ON EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER

NEXT HEARING:
April 15, 2016
9:00 a.m.
Department 43

Petitioner and applicant Jonee Fonseca has applied for a temporary restraining order directed to Kaiser Permanent Roseville Medical Center—Women and Children's Center concerning medical care and intervention provided to her son Israel Stinson. The court convened a hearing on the application at which Ms. Fonseca and her counsel, Alexandra Snyder, Esq., appeared. Various representatives from Kaiser including Katherine Saral, Esq., and Madeline Buty, Esq., appeared by phone.

The court orders as follows:

(1) The application for temporary restraining order is set for hearing

April 15, 2016, 9:00 a.m., in Department 43 of this court, the Hon. Michael W. Jones, presiding. Department 43 is located at the Hon. Howard G. Gibson Courthouse, 10820 Justice Center Drive, Roseville, in the Santucci Justice Center.

(2) Pending further order of the court, respondent Kaiser is ordered to continue to provide cardio-pulmonary support to Israel Stinson as is currently being provided.

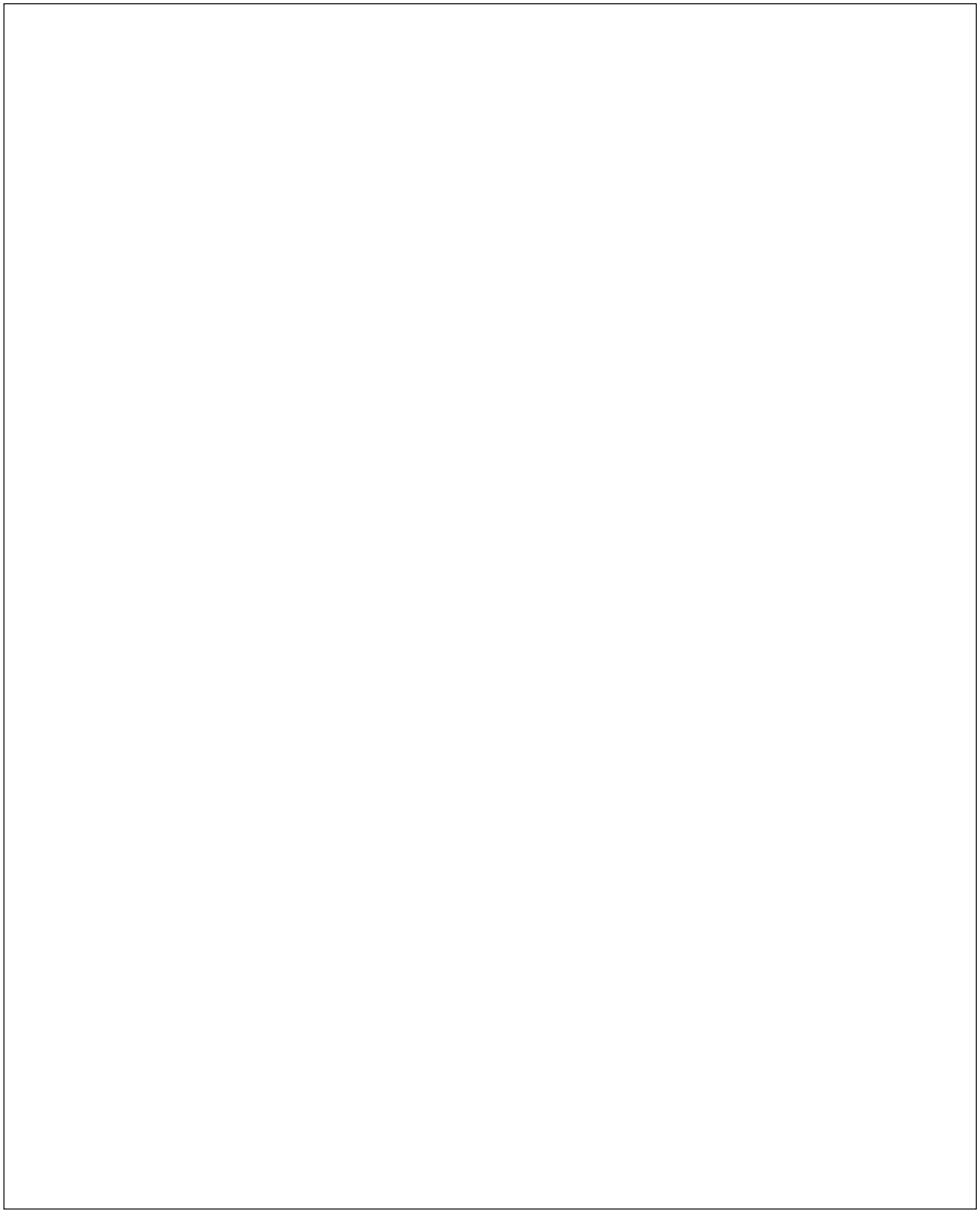
(3) Pending further order of the court, respondent Kaiser is ordered to continue to provide medications currently administered to Israel; however, physicians or attending staff may adjust medications to the extent possible to maintain Israel's stability, given his present condition.

IT IS SO ORDERED.

DATED: April 14, 2016

Alan V. Pineschi
Judge of the Superior Court

EXHIBIT C



SUPERIOR COURT OF CALIFORNIA

COUNTY OF PLACER

DEPARTMENT NO. 43 HON. MICHAEL W. JONES, JUDGE

ISRAEL STINSON,

Plaintiff,

vs. Case No. S-CV-0037673

U.C. DAVIS CHILDREN'S HOSPITAL,

Defendant,

---o0o---

REPORTER'S TRANSCRIPT

Friday, April 15, 2016

PETITION HEARING

---o0o---

APPEARANCES:

FOR THE PLAINTIFF:
LIFE LEGAL DEFENSE FOUNDATION
BY: ALEXANDRA M. SNYDER, Attorney at Law
P.O. Box 2015
Napa, CA 94558

FOR THE DEFENDANT:
BUTY & CURLIANO LLP
BY: DREXWELL JONES, Attorney At Law
516 16th St
Oakland, CA 94612

Court Reporter: Jennifer F. Milne, CSR NO. 10894

INDEX OF WITNESSES

PLAINTIFF'S:	DIRECT	CROSS	REDIRECT
MYETTE, Michael	13	--	--

DEFENSE:

(NONE CALLED)

INDEX OF EXHIBITS

PLAITIFF'S	I.D.	RECEIVED
(NONE MARKED)		

ROSEVILLE, CALIFORNIA

APRIL 15, 2016

---o0o---

The matter of ISRAEL STINSON, Plaintiff, versus U.C. DAVIS CHILDREN'S HOSPITAL, Defendant, Case No. S-CV-0037673, came regularly this day before the HONORABLE MICHAEL W. JONES, Judge of the Superior Court of the State of California, in and for the County of Placer, Department Number 43 thereof.

The Plaintiff was represented by ALEXANDRA SNYDER, Attorney at Law.

The Defendant was represented by DREXWELL JONES, Attorney at Law.

The following proceedings were had, to wit:

---o0o---

THE COURT: Let's call the matter of Israel Stinson. And the caption I have is versus U.C. Davis Children's Hospital, et al. "Et al" being Kaiser Permanente Roseville Medical Center, Women's Children Center.

MR. JONES: Good morning, Your Honor. Drexwell Jones for Kaiser Foundation Hospital. I have with me Dr. --

DR. MYETTE: Michael Myette, M-y-e-t-t-e, and I'm the attending physician of record.

THE COURT: Thank you.

MS. SNYDER: Alexandra Snyder for Jonee Fonseca. And this is Jonee Fonseca, Israel Stinson's mother.

THE COURT: Good morning, folks. Make yourself comfortable.

MS. SNYDER: Thank you.

THE COURT: All right. Apparently you folks have received an ex parte -- order on an ex parte application for a temporary restraining order, and the matter was sent here this morning for further proceedings on this matter.

And neither one of you have requested or brought with you a court reporter?

MR. JONES: No.

MS. SNYDER: No.

THE COURT: The Court is going to have Madam Reporter here report the proceedings for the Court's purposes.

All right, folks. Before we start, I'm just going to make one disclosure, and that's myself, like many employees of government entities and agencies, I'm a member of Kaiser and receive my medical services from there; as well when I was in private practice and the senior partner of my firm, that was the health care provider provided to my employees. It has no effect in

my opinion on anything. That's why I'm continuing with this matter, but I make that disclosure to each side for you to address it accordingly if you wish to. All right.

Let's see. Judge Pineschi then signed this order yesterday. And by that, I'm referring to the order on the ex parte application for the temporary restraining order, having set the matter here this morning.

Let me start with a couple of questions I have in reviewing the limited information that I have. And one of the first questions that I have is whether there is another parent; what is the status of that parent? Let's start with those couple of questions first.

MS. SNYDER: Yes, Your Honor. There is another parent. The father is Nathaniel Stinson. He is -- he is actually outside calling another -- an outside physician, but he is here in the building.

THE COURT: Okay. By him being here, then, he is aware and has received notice of these proceedings for today?

MS. SNYDER: Yes. Yes, he has.

THE COURT: Do you know -- is he --

MS. SNYDER: He is here. There is some concern, too, that their son not be left unattended. So he's, I think, working out who's going to be in the hospital with -- with Israel at this time while his parents are

here in court.

If you would like him to come in, we can -- I think we can have him come in.

THE COURT: That's exactly where I'm going.

MS. SNYDER: Yes. So let's do that.

THE COURT: Hold on. Let's do it one at a time.

If he is present, I want him to be here in the courtroom as well because I -- I need to have a few questions for him as well. So, please. We'll adjourn for a moment to get him.

MS. SNYDER: Thank you.

(Brief recess.)

THE COURT: All right. Ms. Fonseca has rejoined us.

And you are Mr. Nathaniel Stinson, sir?

MR. STINSON: Yes.

THE COURT: Good morning, sir.

MR. STINSON: Good morning.

THE COURT: Okay. Now, we have both parents present.

You are, indeed, the father of Israel Stinson?

MR. STINSON: I am.

THE COURT: Okay. Thank you.

All right. So we are on, at this time, on the application for the temporary restraining order, the

hearing being set today.

So, Ms. Snyder, where are we with this proceeding?

MS. SNYDER: So, as you mentioned, we -- we have a temporary restraining order that was in place through this hearing this morning. And at this time, we are requesting that that order, plus nutrition, be extended for two weeks so that Israel's parents can find an outside doctor to do another evaluation and possibly transfer him to another facility. So we worked very hard last night to find another doctor who said he would review Israel's records. He is not in the state, and he is actually currently on a trip in St. Louis. But he said he would review the records and then refer the case to a California doctor who could examine Israel in person.

Essentially we're asking for what the California Health and Safety Code provides in Section 7181 in the form of an independent confirmation by another physician.

THE COURT: And the basis for -- before I hear a response from Mr. Jones on behalf of Kaiser, the basis for the request to include at this time nutrition and also the basis for the extension for two weeks, if you could address both of those.

MS. SNYDER: Yes. So the nutrition was

recommended by the doctor that we consulted with. He wanted to make sure that -- that as much treatment as possible was provided, including basic nutrition so that essentially the child wasn't starved over the next period of time.

And the two-week time frame --

THE COURT: Let's stick with the nutrition for a moment.

MS. SNYDER: I'm sorry.

THE COURT: First of all, the doctor, is this a neurosurgeon? A pediatric?

MS. SNYDER: He is a pediatric neurologist.

THE COURT: But not from this state?

MS. SNYDER: No. But he does consult with physicians from the state and would be able to refer a -- refer the parents to a California physician.

THE COURT: Okay. And with respect to nutrition, that's, as you can imagine, very broad.

MS. SNYDER: Yes. And I am not -- unfortunately, I am not a physician so --

THE COURT: But you spoke to one.

MS. SNYDER: I did. I did. And he -- I mean, he said "nutrition" but did not go into specifics. I am sure we can have him provide specifics. He did -- he did provide us with a medical directive. I can provide you a

copy, if you'd like. But he would like to go with Israel's chart.

THE COURT: Have you shown that to Mr. Jones?

MS. SNYDER: I have not.

(The Court and Madam Clerk confer sotto voce.)

THE COURT: Okay. Anything further on the nutrition aspect?

MS. SNYDER: No. But, again, we -- I'm sure we can get specifics from -- from the doctor who provided us with the medical directive.

THE COURT: Well, assume if I were to give some period of time of extension for the temporary restraining order. Wouldn't one of the questions that would be asked by Kaiser be some sort of directive in terms of what does nutrition mean?

MS. SNYDER: Yes, and we did -- we did discuss -- spent quite a bit of time discussing this yesterday afternoon in terms of the specifics, and I did -- again, I contacted Dr. Byrne about that. So, yes, absolutely. There would be questions, and we can provide those answers. We just need a longer consult with the doctor.

THE COURT: Okay. Let's go to that, then. Let's turn to the two weeks.

MS. SNYDER: Okay. So the two-week period of

time, I believe, would be sufficient to allow our out-of-state doctor to review Israel's records, provide a referral to a California physician, allow time for that physician to come to Roseville to examine Israel, and then also allow time for -- to make arrangements for another facility.

We started that process yesterday evening but it's -- it's difficult. So we have found a potential location for him that's out of state. His parents would prefer not to go out of state. They have another child. They have a lot of family here. And right now they really need that support from their family.

So we are hoping to find a facility, a suitable facility in California, but that may take a little bit of time. Those beds are not always immediately available.

THE COURT: I understand. All right. Thank you.

Mr. Jones, maybe I should have started with -- if there's even any objection. I assumed by virtue of the fact that you appeared yesterday on the restraining order and voiced concerns that you have some position at least to the request now to continue the temporary restraining order and to include a nutrition aspect and also for the extension for a two-week period of time.

So if you could address those two issues and any

others you wish to at this time.

MR. JONES: Yes, Your Honor. First, I just want to kind of point out that this case is not a persistent vegetative case -- persistent vegetative state case where there's a question about the functioning of the body.

Yesterday, Israel was declared to be dead pursuant to California law.

And, you know, no -- you know, through no fault of the petitioner, there are facts missing from the petition. And I think it might be beneficial for the Court to hear from a doctor the clinical course and the current status of Israel. Because it seems like, looking at the document counsel presented for the medical directive, it seems to kind of be missing the point that the -- under the law, the examinations to determine brain dead have been done.

Kaiser was the independent facility that Israel was transferred to to make that determination. U.C. Davis, where he was at previously, did the first examination for brain death and found the test to be consistent with brain dead.

The parents objected to U.C. Davis performing that test and had him transferred to Kaiser. Then when Israel gets to Kaiser, Kaiser agrees to perform -- basically, he was brought to Kaiser for this specific

purpose of determining brain death.

Another test is done, as an independent facility. And it confirms, in fact, that Israel is dead.

Another test, a third test, was performed yesterday, evaluation, a neurologic evaluation and apnea test, found that he is brain dead. He was declared dead yesterday.

There's been no challenge to the accuracy or credibility of the testing that's been done. There is nothing that suggests that there should be a -- what amounts to a fifth examination into whether or not Israel is dead because he, in fact, is.

So I kind of just want to go back -- and maybe if we had a rundown of sort of the clinical course from the doctor, it might frame things a little bit different than they are in the petition. And, again, I'm not saying that anyone is trying to be inaccurate in the petition, but it was -- you know, the information therein was provided by a lay account. And there's some information that might be beneficial to the Court if the Court wouldn't mind hearing from a doctor.

THE COURT: All right. I'll hear from Dr. Myette too at this point to at least provide the Court with more information in terms of the status of where we are with the various petitions.

So, Dr. Myette, I'm going to ask that you please stand, sir, and be sworn.

(Whereupon the witness was sworn.)

THE WITNESS: I do.

THE CLERK: Please state your full name for the record.

THE WITNESS: Michael Steven Myette.

THE CLERK: Please be seated.

THE COURT: All right. You can just remain there for this purpose, sir.

Go ahead

DIRECT EXAMINATION

BY MR. JONES:

Q. Doctor, first off, what is your title?

A. I am a pediatric intensivist, and I'm board-certified in pediatrics and in pediatric critical care medicine. And I'm the medical director for the pediatric ICU at Kaiser Permanente in Roseville.

Q. And how long have you practiced medicine?

A. I have -- I have worked at Kaiser for -- it will be 11 years this July. Prior to that, I did my critical care in fellowship at U.C. San Francisco. And prior to that, I did a pediatric residency at U.C. Davis.

MR. JONES: Your Honor, I'd like to qualify this witness as an expert witness as well as a treating

physician.

MS. SNYDER: Excuse me. I'm sorry, Your Honor. But I was under the -- we were under the understanding that we would not be calling witnesses, specifically medical witnesses, because of the short time frame, that there would be no time for us to call a witness.

In fact, Kaiser asked us if we would call a medical witness, and we said we would not. And the understanding was that they would not either because their witness is ten minutes from here and ours is 2,000 miles from here. So -- and we had 15 hours to prepare for this hearing this morning.

THE COURT: I understand.

MS. SNYDER: Okay.

THE COURT: What I'm doing at this point in time is Kaiser wants to present some further information for the Court on these issues. And in terms of me receiving that information, since we have the doctor here, I might as well receive it in a proper fashion under oath.

MS. SNYDER: Okay.

THE COURT: Would you agree with that, that if he is going to say something, it might as well be --

MS. SNYDER: I do agree with that, yes.

THE COURT: Okay. Thank you. Go ahead, sir.

BY MR. JONES:

Q. And have you been involved with the care of Israel Stinson?
A. Yes. I received him in transfer from U.C. Davis Medical Center on April 12th and cared for him through yesterday. I -- I documented his time of death yesterday at 12:00 noon.
Q. Have you had an opportunity to review the medical records from U.C. Davis?
A. Yeah. I -- I extensively reviewed the medical records at U.C. Davis, the course of his care there, which I can summarize, if you want me to.
THE COURT: That's okay.
BY MR. JONES:
Q. Can you summarize the care.
A. Okay. Israel presented with a condition called status asthmaticus to an outside hospital in the Mercy system.
The emergency physicians treating him were concerned at the severity of his asthma. He was initially treated with medicines to take care of that. Ultimately, it was determined that he required assistance with a ventilator.
THE COURT: How old is Israel?
THE WITNESS: Israel is a 30-month-old boy. He is 2 1/2 years old.

THE COURT: Okay.

THE WITNESS: So he had an intratracheal tube placed in his trachea and was put on a ventilator. This intervention placed the child beyond the scope of care of the facility in the Mercy system. So they contacted U.C. Davis Medical Center who agreed to accept the patient in transfer.

BY MR. JONES:

Q. And what date was that, Doctor?

A. April 1st.

Q. And the transfer was April 2nd?

A. The transfer was April 1st.

Q. Okay.

A. The patient was cared for overnight in the pediatric ICU at U.C. Davis Medical Center.

On the 2nd of April, the physicians determined that he had improved and the intratracheal tube, breathing tube, was removed.

He was continued to be treated for his asthma at that point with Albuterol and other medications.

A few hours after excavation, he began to develop a very acute respiratory distress. The doctors attempted to treat that with rescue medications, but he developed a condition called a bronchospasm where his airway squeezes down so tight that air can't pass through

it.

The U.C. Davis doctors did multiple rescue attempts including replacing the intratracheal -- the breathing tube.

Even with the intratracheal breathing tube in place, they could not adequately force air into the portion of his lung where oxygen is exchanged.

During this episode, Israel's heart stopped. He was resuscitated with cardiopulmonary resuscitation, chest compressions, and continued attempts to force air into his lungs through the intratracheal tube.

Q. For how long?

A. 40 minutes this went on.

I spoke directly with one of the physicians of record who told me that they had a terrible time trying to get air in his lungs.

As hard as they pushed, they could not seem to bypass this -- the spastic airway and get air into the portion of his lung where it would be life sustaining.

After 40 minutes of cardiopulmonary resuscitation, he was cannulated for a machine called ECMO. It's spelled E-C-M-O. It is a machine. It stands for Extracorporeal Membrane Oxygenation.

ECMO is a machine that is analogous to a heart-lung bypass machine when somebody is getting heart

surgery. But unlike that machine, it is used in an intensive care unit to act in lieu of a heart and lungs when the heart and lungs aren't functional but the physicians believe that the condition is reversible.

He remained on the ECMO circuit for four days at U.C. Davis Medical Center.

The asthma and the subsequent cardiac arrest were, in fact, reversible. And his heart functioned -- started to function on its own after -- after a time as did the -- the bronchospasm in his lungs improved also over time with medication.

He was decannulated, which is to say taken off of the ECMO circuit on April 6th.

On April 7th, he had a procedure, a nuclear medicine procedure at U.C. Davis, called radionuclide. It's spelled r-a-d-i-o-n-u-c-l-i-d-e, I believe.

Radionuclide scan, which is a scan which measures uptake of oxygen and nutrients, glucose and such, into the brain. That is often used as an ancillary test. It is not a test that you can use to determine brain death in and of itself. It doesn't substitute for a brain death exam. But in cases where a complete brain death exam is not -- is not able to be done, it can be an ancillary piece of information. That's why I bring it up because it's supporting information.

The radionuclide scan was read by a radiologist and confirmed as showing no -- no uptake of oxygen or nutrients by Israel's brain.

On the 8th of April, one of the U.C. Davis Medical Center pediatric intensivists, somebody who is trained in the same manner and board-certified in the same manner that I am, performed an initial neuro exam attempting to see if there is any evidence of brain function.

That exam, including an apnea test, suggested that there was -- that there was no -- no brain activity. It was consistent with brain dead -- brain death.

Q. What's an apnea test?

A. An apnea test is a test whereby you take a patient off of a ventilator. You get them physiologically into a -- into a normal state as possible, normal oxygen in their blood, normal CO2 in their blood.

And you cease blowing air into their lungs. You place them on ambient, 100 percent oxygen, so that they are still able to deliver oxygen to their body during this test.

But the human body doesn't -- doesn't use oxygen or lack of oxygen to drive our desire to breathe. Our desire to breathe is driven by carbon dioxide in the

blood.

So this test is a test whereby we -- without letting a patient become dangerously deoxygenated, we allow the carbon dioxide to increase to a point where the portion of their brain that regulates carbon dioxide and tells the body to take a breath will respond. We actually go way beyond that.

The specifics of that test are available in the paper, and I can -- I can go into more detail if you want.

But the apnea test went on for -- I don't remember exactly how long she documented, but I think it was somewhere in the neighborhood of six to eight minutes, which is fairly typical for an apnea test.

The recommendations, as put forth by the American Academy of Pediatrics, the Society of Child Neurology, and the Society of Critical Care Medicine, who have issued a joint statement on how to go about these things states that you need to have normal CO2 at the beginning of the test. And you need to have a jump of at least 20 millimeters of mercury during the course of the test for the test to be valid.

The test was done -- was documented blood gasses before and after the apnea, the period of nonbreathing, were done and confirmed that there was an adequate reason

in Israel's CO2 that should have triggered his body to take a breath if that portion of his brain that -- that regulates when to take a breath was -- was functional.

On the 8th, the clinical neuro exams were conducted.

It is customary and it is recommended somebody -- somebody that is Israel's age you have to wait a minimum of 12 hours in between two separate exams of this nature.

The first exam establishes that there is no function. The second exam is supposed to confirm that whatever caused the first exam results to be what they are is -- was not, in fact, reversible.

In terms of Israel, he has not received any medications for pain or sedation since April 2nd.

He has not received any -- anything that would depress brain function since April 2nd.

Q. Was there a second test conducted at U.C. Davis?

A. There was not a second test done at U.C. Davis. The family -- well, the family requested some scans be done.

They asked for -- on the 9th or 10th -- I don't remember which day. But on the 9th or 10th, they requested a CT scan of the head be done and an MRI of the

brain be done.

U.C. Davis complied with this request and actually did both scans. The CT scan of the brain, which they sent to us also with his medical records, was read as showing diffused brain swelling, effacement of the basal cisterns, and herniation of the brain stem out the foramen magnum.

The foramen magnum is the hole at the base of the skull where the spinal cord comes out. And if the brain swells enough, then a portion of the brain, just by the pressure from all that swelling, can be forced down through that hole.

While that is not part of a brain death exam, per se, that is an unsurvivable event.

Q. Irreversible?

A. Irreversible.

Q. Then what happened?

A. The MRI also confirmed severe global injury to the brain and also confirmed the transforaminal, across the foramen herniation of brain tissue of the brain stem.

Q. Did the parents object to a second test at U.C. Davis?

A. The U.C. Davis doctors document that there was objection to doing a confirmatory brain death test.

The family requested that Israel be transferred

to U.C. Davis -- excuse me -- to Children's Hospital and Research Center in Oakland -- or now, I guess, the UCSF Benioff Children's Hospital in Oakland is the current name.

The physicians at U.C. -- or at UCSF Benioff Oakland Children's Hospital refused the transfer. They declined to take the patient in transfer.

Then -- I don't know -- the circumstances aren't 100 percent clear to me, but I came into the -- into the fold when I received a call from our outside services and asking me if I would be willing to take -- to take Israel in transfer.

Realizing that this was a difficult and tragic set of circumstances and understanding that probably the family had mistrust of the physicians at U.C. Davis because that's where the initial event, the initial cardiopulmonary arrest occurred, was likely to make it very difficult for them to accept whatever U.C. Davis was going to tell them, I agreed to transfer the patient to my intensive care unit and to evaluate him on my own.

Q. For brain death?

A. For brain death, correct.

Understand that I -- I evaluate a patient not looking for brain death, per se, but looking for absence of brain death. It is a vital part of information for me

to be able to figure out what the nature of care I need to deliver to this boy.

Had I done my initial exam on him and discovered that there was some activity in his brain, we wouldn't be here. I'd be -- we'd be -- we would not have declared him dead, and we would be attempting to facilitate whatever recovery he would have been capable of.

Q. When was he transferred to Kaiser?

A. He was transferred to Kaiser on April 12th. He arrived in the early afternoon.

Q. When was -- when was the first test conducted?

A. The first test done at Kaiser -- I did that test, but it wasn't done until about 11:00 o'clock p.m. that night.

The delay was that, as I had mentioned earlier, a patient has to be in a normal physiologic state for a brain death exam to be valid.

And Israel is unstable. The portions of his brain that autoregulate all the things that we take for granted, his brain is not doing that.

So illustration: When he came to me, his body temperature was 33 degrees centigrade. Normal body temperature is 37 degrees centigrade. He doesn't regulate his body temperature. If he gets cold, he doesn't shiver. If he gets cold, his body won't alter

its metabolic rate to increase heat production.

And so he is not -- if left alone, he will drift to ambient temperature, room temperature.

So when he got there, he had dropped from 36 to 37 degrees at U.C. Davis. The transfer, being in the ambulance and being in a -- in that environment was enough to drop his temperature four degrees centigrade.

So I had to spend several hours gently warming his body back up, which we instituted shortly after arrival. This is not something you want to do quickly because you can overshoot. And somebody who has a brain injury who gets a fever is likely to have a worsening of that brain injury. So we have to be very careful not to cause a fever.

So at that point, I began gentle warming. Another problem that had occurred when he arrived was that -- our pituitary gland in our brain regulates our water and salt balance in our body. To simplify, sodium and free water.

A hormone called vasopressin secreted by the pituitary gland keeps all of us in -- in normalcy for water and sodium. Well, his brain doesn't -- isn't doing that now. His pituitary gland is not functioning. So he was placed on an infusion of -- of manufactured -- of pharmaceutical vasopressin, which we have. And that is a

hormone that the body has this variable sensitivity to. And so you have to monitor him very closely.

When he had his brain death exam at U.C. Davis, his sodium was in the normal range. But by virtue of time, when he got to me, his sodium level was elevated, also elevated to a point at which I couldn't have done a valid brain death exam. So I had to -- I had to manage that level of sodium by altering the level of vasopressin I was infusing into his body to get his sodium into a physiologic range.

Q. Doctor, let me just ask this: Is the function of those organs not occurring because the brain is just not sending any signals of how organs have to operate?

A. That's correct. The kidneys regulate sodium and water based on signals they receive from the brain.

So while -- while Israel's kidneys in and of themselves are fine, they are not receiving the signals to do their job.

So that was the problem. He has wild fluctuations in his level of free water in his body, which can drive his sodium dangerously low or if we take away -- if we don't supplement that hormone, then he will pee out -- for lack of a better word, will urinate all the free water in his body and will go into cardiovascular collapse and die, and we will see that --

we would see that based on his sodium drifting up into levels that are not physiologic.

Q. So what test did you perform on the 12th?

A. So after getting his body warmed up to physiologic temperature, between 36 and 37 degrees centigrade, and after readjusting his vasopressin infusion to make sure that his sodium was between 130 and 145, I achieved that physiologic state at about 11:00 o'clock p.m., and then I performed a comprehensive neurologic exam looking for evidence of brain function.

I can go into the specifics of that test, if you want.

Q. What were the results of the test?

A. The results of my tests were consistent with no brain function. There was no evidence of his brain receiving any signals from his body, nor was there any evidence that his brain was regulating any organs in his body.

Q. And you performed an apnea test as well?

A. Correct. My apnea test lasted for seven and a half minutes with Israel on 100 percent oxygen. And his carbon dioxide in his blood at the beginning of the test was in the normal range, between 35 and 45. And at the end of the test, his carbon dioxide was 85. So there was a significant increase in that -- a level of increase

that would, in anybody with any function of their brain stem, cause them to draw a breath. And we -- we had a monitor on his intratracheal tube looking for any CO2, any exhale or there were -- there were sensors on his body sensing any inhale of breath.

Q. Did you also repeat that test yesterday?

A. Yes. So I did not do -- I want to be clear, I didn't do the confirmatory brain death exam. The recommendations by National is for two separate physicians to do the two different exams so that you have a fresh set of eyes.

And one of my colleagues, Dr. Masselink, spelled M-a-s-s-e-l-i-n-k, who is a board-certified pediatric neurologist performed the confirmatory neurologic test yesterday at 11:00 o'clock in the morning. That was a full 36 hours after the first test.

In the room accompanying and witnessing that test with him was Israel's great aunt and one of his grandmothers. And also Dr. Shelly Garone, who is one of -- one of my bosses -- one of the -- they're called at Kaiser -- they're called APIC. It stands for Associate Physician In Chief. And she -- she was also present for that.

Q. What were the results of the tests?

A. The results of that test, as documented by

Dr. Masselink, were that there was no -- no evidence of any brain function, that the exam was consistent with brain death.

Q. And was there a declaration of death made?

A. Yeah. Well, let me add one more thing.

A second apnea test was done as is -- as is in the recommendations put forth by the National Societies, as I previously mentioned.

So I did a second apnea test. The rules of brain death say that the same physician can do both apnea tests because it's appropriate that either a pediatric critical care doctor or a pediatric anesthesiologist, somebody with advanced airway skills, perform the apnea test. That's the one part of the exam that is beyond the scope of a pediatric neurologist.

So after Dr. Masselink completed his exam, the final piece was a confirmatory apnea test, and I did a confirmatory apnea test. This time I actually let it go for a full nine minutes, waiting to see if Israel would [Witness makes a descriptive sound] -- would draw a breath.

And after nine minutes, and CO2 that went above 90, he did not draw a breath.

At that point, I terminated the apnea test, and it met requirements for a valid test.

Q. And at that point --
A. At that point, I documented -- I wrote a death note and documented Israel's time of death at 12:00 noon, yesterday.
Q. How difficult is it to maintain, essentially, the body -- now that there's been a declaration of death, what efforts are required in order to keep Israel in the condition that he currently is, which I understand is not very stable?
A. Yeah. That's -- that's a good question. I mentioned earlier that the brain sends the signals that regulate our salt and free water.

And try as we might, doctors are not as good as a working brain at doing this. We're certainly doing our best.

But I can tell you that between Israel's arrival on the 12th and when I signed off to my colleague, another pediatric intensivist last night at 8:00 o'clock p.m., that I did not leave the hospital. I was always either in -- in the ICU, in the room with Israel, or over in my office, which is in the same building right around the corner. I took a couple of two- or three-hour naps in the sleep room, which is within 30 feet of the intensive care unit.

The reason being that throughout the night, from

the time he arrived until the time I signed him off, I was microadjusting his vasopressin infusion, making sure that his sodium did not drift too high or too low. I was adjusting another infusion that I hadn't mentioned yet, a medicine called norepinephrine or noradrenaline. It is a synthetic cousin to our own adrenaline that our body secretes.

Israel's body doesn't secrete that anymore. As a result, his blood pressure without this medicine will drift low to the point where he will not perfuse his coronary arteries, and his heart will stop. He is absolutely 100 percent dependent on this infusion of norepinephrine to keep that heart beating.

So if you give too much of that medicine, again, people have varying sensitivities to it. It's not a simple dose, and you get a blood pressure. You have to see what dose will produce a blood pressure.

He has an invasive arterial line in his femoral artery that gives us a moment-to-moment reading of his blood pressure. And using that catheter and transducing that pressure onto a monitor continuously, I adjust the norepinephrine.

He has -- I can't tell you exactly how many times, but I can tell you it's more than 20 that I've adjusted that medicine. Okay. I am trying to keep his

main arterial pressure, which is somewhere between the systolic and diastolic. I can get more specific than that if you need but that's probably adequate. I want to keep that main at least 60 and not above 100.

Below 60, and I don't adequately perfuse his kidneys or his heart.

Above 100, and the pressure in the arteries is high enough that I run the risk of him having a bleeding -- a bleeding episode or a hemorrhage.

So that moment-to-moment, minute-to-minute, and hour-to-hour management of his blood pressure, and that moment-to-moment, hour-to-hour management of his salt and free water levels in his body are something that requires a physician be present virtually all the time.

Q. Are Israel's organs essentially beginning to atrophy? Are they failing?

A. The -- this is what we normally see happen. There are exceptions to this. I think there's a -- Mom and Dad mentioned a case where somebody who had seen total cease of brain function has continued for a long time to have a beating heart. I don't know the specifics of that case.

But I can tell you in my experience -- I have precedent for trying to keep the heart beating after somebody has been declared dead. The specific situation

where we do this is when a family wishes organ donation. Because if the heart keeps beating and keeps delivering oxygen and glucose to the organs that are still functional, then those organs can be transplanted into somebody who needs them.

And so in situations where families wish organ donation, often when somebody has been declared brain dead, we, intensivists, as a bridge to get these organs to transplant, will work very hard to keep a patient alive or -- that's not -- scratch that. Not to keep -- to keep a patient's organs functioning and keep a patient's heart beating. And it does get more challenging the longer we do it.

Now, we're on top of this right now with Israel. We're working very hard, but we're on top of this. But the notion that he is stable and sitting in a corner and everything is running on autopilot is -- is a notation that is not grounded in reality. He is aggressively, acutely managed moment to moment.

THE COURT: And is nutrition an aspect of that?

THE WITNESS: So nutrition is a little bit problematic. So I can tell you -- we are providing him with a constant infusion of glucose to make sure that his blood sugar remains in normal range.

His intestines -- and intestines in situations

where there's a prolonged resuscitation often suffer a pretty significant injury.

And before we put nutrition into the gut, into the intestines, we need to know that those intestines have healed. If you put a bunch of sugar and protein and fat into a gut that is severely injured, that sets up a situation where pathological bacteria can grow in that nonfunctioning gut. And you can have catastrophic complications.

So we are not feeding him into his intestine right now because his intestines have not yet indicated to us that they are capable of handling and absorbing nutrition and putting -- putting nutrition into the intestines at this point is -- would be a very risky thing to do.

Now -- I guess I'll leave it at that.

So the short answer is beyond IV glucose infusions and IV infusions of salts and electrolytes, that's the only nutrition he is getting right now.

THE COURT: Okay. Mr. Jones, anything further?

BY MR. JONES:

Q. What -- what is the likelihood that you would be able to maintain Israel's body in this state for a two-week period of time?

A. It will be difficult. I guess that's the best I

can say. I don't -- I don't know, you know. I don't know what he is going to do. I can tell you that last night that Israel's sodium dropped to a level that in somebody with a functioning brain would have caused seizures. And the doctor who was taking care of him last night had to stop the vasopressin infusion altogether because his sensitivity to it suddenly went up.

And the sodium is coming back up now because the body is starting to get rid of that free water that was holding on, was diluting the sodium in his body.

So we are -- we are monitoring him very closely. But as I said earlier, no physician is as good as a functioning brain at regulating the physiology of a human body. And anyone who thinks they are is naive or arrogant. But, you know, we'll try. We're going to keep trying, but I can tell you that those kinds of fluctuations are going to happen. And it may be that one of them happens and his body just shuts down.

Often what I see in kids who go on to transplant is that at some point their body stops responding to the adrenaline that we infuse and their blood pressure starts to drop. And that also can be problematic. That has not happened yet with Israel, but it could happen today. It could happen tomorrow, and we could pour more and more into him and try our best to keep that blood pressure up.

In my experience, sooner or later, our efforts to mimic the brain starts to fall short.

THE COURT: I understand. Anything further, Mr. Jones?

MR. JONES: Just with that background -- I just want to point out to the Court that -- so we're here to determine whether or not the temporary order should be continued.

And my comment is that under Health and Safety Code Section 7180 and 7181, Israel has been found to be dead.

THE COURT: And, therefore, the parent should not have the opportunity to have an independent evaluation?

MR. JONES: They had. We are the independent --

THE COURT: They're not entitled to have their own independent evaluation at this point in time, somebody outside of Kaiser?

MR. JONES: I think if they -- if you look at the Dority case --

THE COURT: Just answer my question. Are the parents entitled to have an independent evaluation outside of Kaiser at this point in time?

MR. JONES: No. No. Because there's no --

THE COURT: Your position is no?

MR. JONES: Yes.
THE COURT: Go ahead, sir.
MR. JONES: No, because there's nothing that suggests there need -- there needs to be. There's no complicating factors. There's no -- you know, we're not the facility where, you know, there was care rendered that might be questionable. There is nothing that raises the issue. In fact, if you look at the Dority case which was cited in the paper --
THE COURT: I understand. Dority says that there has to be a sufficient showing of a reasonable probability that a mistake has been made in the diagnosis of brain death or that it was not made in accordance with accepted medical standards. That's the standard in Dority. I'm familiar with it.
I'm also very familiar -- I'll let you both know -- with traumatic brain injury cases, were my specialty, my niche, when I was in private practice. So I'm familiar with that at least from a lay perspective.
MR. JONES: Sure. So there was the -- the test at U.C. Davis, the first one. There was a confirmation at Kaiser and then another confirmation. So there's been three tests, two by the independent facility.
Where in the law is there a suggestion that there should be yet another one? What's the offer of

proof that any of the tests have been conducted improperly or there's some suggestion that the results would be different if we did this one or if we did this 100 times? There is none.

THE COURT: All right. I understand. All right. Thank you.

I'm going to allow the parents that opportunity to see whether or not they can present that evidence. Okay. I'm going to extend -- and, Ms. Snyder, this is without prejudice to you for any further examination should we get to a point of evidentiary hearing and proceeding with respect to bringing back Dr. Myette for examination by her. If it gets to that point. Okay.

But right now, I am going to extend the temporary restraining order and give Mr. Stinson and Ms. Fonseca the opportunity to -- I'm not going to extend it for two weeks, though. I'm not going to do that. I'm going to have us back here next Friday, April 22nd, at 9:00 o'clock in this department.

In the meantime, the order issued yesterday by Judge Pineschi remains in full force and effect until that time with the inclusion that any present nutritional aspect that is being provided will continue in the manner that it has been.

Yes, sir.

MR. JONES: Sorry, Judge.

I just want to raise the do not resuscitate issue. Quite frankly, it is -- it's almost inhumane to the staff to have to treat a deceased body and provide CPR and resuscitate -- if the organs start to fail.

THE COURT: Ms. Snyder.

MS. SNYDER: I believe, Your Honor, the order that is now going to be extended mentions "reasonable efforts."

So the parents certainly understand that their son is -- has suffered a severe injury. They -- they are aware of that, and they -- they know that things could change. We also know that things haven't. He has been -- what the doctors have told the parents is that he has been stable with clearly the assistance of physicians at Kaiser. We are also aware of that and are very grateful of that.

THE COURT: If I can interject. Keep that thought for a moment.

Of all the process I went through this morning, parents, I hope you understand that I've allowed Dr. Myette for the benefit of not only the Court hearing it, but for you hearing it directly from him, as extensive as he has outlined all this information as well. I hope you understand that.

MR. STINSON: Yes, we do. Thank you so much, Your Honor.

THE COURT: Okay. Go ahead. I didn't mean to interrupt.

MS. SNYDER: That's okay. That really was all that the -- the order mentions "reasonable measures."

THE COURT: Well, the order indicates that Kaiser is ordered to continue to provide cardiopulmonary support as is currently being provided and that to provide medications currently administered to him. And they can adjust the medications to the extent possible to maintain his stability, given his present condition. That's what the order states and that's going to continue --

MS. SNYDER: Okay.

THE COURT: -- in effect at this time, along with the now what I've included, so that it's clear, the nutritional aspect of it.

So I'm going to continue with that order. All right. We'll see you folks next Friday, April 22, at 9:00 o'clock in this department. The order will continue to that date and we'll see where we stand at that point in time.

MS. SNYDER: Thank you, Your Honor.

MR. JONES: Sorry. I failed to address one

other important aspect.

So to the degree that an outside physician is going to come to Kaiser and perform an evaluation, they need to be licensed in California. They need to be a -- you know, a physician in the -- you know, trained in a proper field to make a diagnosis of death.

THE COURT: Right. I would -- I would hope that you folks would meet and confer over any such issues and that Kaiser, of course, would make its facilities, testing, measures available to such a person as well.

MR. JONES: We just need about 24 hours to get privileges and do all the work that we need to do on our end.

THE COURT: Well, we are under a one-week time period right now. I know your concerns there. 24 hours -- if they find somebody Thursday at noon isn't going to cut it, right? So, yet, they would be within the time parameters of the order. I would just hope that you folks would work with each other on that.

MR. JONES: We'll do our best.

MS. SNYDER: Thank you. Thank you. We appreciate that very much.

MR. STINSON: Thank you very much, Your Honor.

THE COURT: Does anyone want a written order on this or is this fine?

MS. SNYDER: I think it would be helpful if that's not too much trouble.

THE COURT: I'll provide a written order and additional aspect of it. Thank you, folks.

MS. SNYDER: Thank you.

(The matter was concluded.)

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

---o0o---

ISRAEL STINSON,
Plaintiff,
vs. Case No. S-CV-0037673
U.C. DAVIS CHILDREN'S HOSPITAL,
Defendant,

I, JENNIFER F. MILNE, Certified Shorthand Reporter of the State of California, do hereby certify that the foregoing pages 1 through 42, inclusive, comprises a true and correct transcript of the proceedings had in the above-entitled matter held on April 15, 2016.

I also certify that portions of the transcript are governed by the provisions of CCP237(a)(2) and that all personal juror identifying information has been redacted.

IN WITNESS WHEREOF, I have subscribed this certificate at Roseville, California, this 19th day of April, 2016.

_____

JENNIFER F. MILNE, CSR

License No. 10894

EXHIBIT D

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF PLACER
10820 Justice Center Drive
P.O. Box 619072
Roseville, CA 95661-9072
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[redacted]

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From: Jennifer Tisdale (916.408.6370)
Date: April 15, 2016
Pages 3 including cover

☑ Urgent ☑ For Review ☐ Please Reply ☑ Copy will not be mailed

SUBJECT: S-CV-0037673 Stinson vs. UC Davis Children Hospital

4-15-16 ORDER ON EX PART APPLICATION FOR TEMPORARY RESTRAINING ORDER

FILED
Superior Court of California
County of Placer
APR 15 2016
Jake Chatters
Executive Officer & Clerk
By: J. Tisdale, Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF PLACER

ISRAEL STINSON by and through JONEE FONSECA, his mother
Petitioner;
v.
UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER-WOMEN AND CHILDREN'S CENTER,
Defendants

Case No.: S-CV-0037673

ORDER ON EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER

NEXT HEARING:
April 22, 2016
9:00 a.m.
Department 43

Petitioner and applicant Jonee Fonseca has applied for a temporary restraining order directed to Kaiser Permanent Roseville Medical Center—Women and Children's Center concerning medical care and intervention provided to her son Israel Stinson. An initial TRO was granted April 14, 2016, and further proceedings were set for April 15, 2016, 9:00 a.m., in Department 43, the Hon. Michael W. Jones, presiding.

The April 15 hearing was conducted as scheduled. Ms. Fonseca and Nathaniel Stinson, minor's father, appeared with Alexandra Snyder, Esq. Drexwell M. Jones, Esq., appeared for Kaiser along with Dr. Michael Myette.

After consideration of the information and argument presented, the court orders as follows:

(1) The temporary restraining order issued previously is extended to April 22, 2016, 9:00 a.m., or further order of this court, with additional orders as follows:

(a) Respondent Kaiser is ordered to continue to provide cardio-pulmonary support to Israel Stinson as is currently being provided.

(b) Respondent Kaiser is ordered to continue to provide medications currently administered to Israel; however, physicians or attending staff may adjust medications to the extent possible to maintain Israel's stability, given his present condition.

(c) Respondent Kaiser is ordered to continue provision of nutrition to Israel in the manner currently provided to the extent possible to maintain Israel's stability, given his present condition.

(2) The application for temporary restraining order is set for further hearing April 22, 2016, 9:00 a.m., in Department 43 of this court,

IT IS SO ORDERED.

DATED: April 15, 2016

Hon. Michael W. Jones
Judge of the Superior Court

EXHIBIT E

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF PLACER

---o0o---

ISRAEL STINSON by and through JONEE FONSECA, his mother,

Petitioner,

vs. Case No. S-CV-0037673

UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER - WOMEN AND CHILDREN'S CENTER,

Defendants.
_____/

Petition Hearing

Friday, April 22, 2016

Reported by: Ruth E. Diederich Hunter, RPR, CSR
CSR No. 4952

APPEARANCES OF COUNSEL:

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(510) 267-3000

ALSO PRESENT:

COUNTY OF PLACER, OFFICE OF COUNTY COUNSEL
By: ROGER COFFMAN, Senior Deputy County Counsel
175 Fulweiler Avenue
Auburn, California 95603
(530) 886-4630

Jonee Fonseca
Nathaniel Stinson

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ROSEVILLE, CALIFORNIA

April 22, 2016

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The matter of Israel Stinson, by and through Jonee Fonseca, his mother, Petitioner, versus UC DAVIS Children's Hospital; Kaiser Permanente Roseville Medical Center - Women and Children's Center, Defendants, Case number S-CV-0037673, came regularly this day before the Honorable MICHAEL JONES, Judge of the Superior Court of the State of California, in and for the County of Placer, Department Number 43 thereof.

The Petitioner was represented by ALEXANDRA M. SNYDER, attorney at law, acting as Counsel.

The Defendants were represented by JASON J. CURLIANO and DREXWELL M. JONES, Attorneys at Law, acting as their Counsel.

The following proceedings were had, to wit:

--oOo--

THE COURT: All right. Let's call the matter of Israel Stinson vs. UC Davis Children's Hospital, et al., effectively Kaiser is the party who is present here for these proceedings.

We have the parents who are present for Israel -- good morning to you folks -- who is represented by Ms. Snyder. We also have on behalf of

the Kaiser facilities Mr. Jones here once again.

Good morning.

MR. JONES: Good morning, your Honor.

THE COURT: And you have somebody else with you at counsel table.

MR. CURLIANO: Good morning, your Honor. Jason Curliano on behalf of the Kaiser Foundation Hospitals.

THE COURT: Good morning, Mr. Curliano.

Good morning again to each of you here.

We are on this morning, as you all know, for discussion of the restraining order that was issued previously and then extended by this Court to today's date and time for additional information to see where we stand with respect to dissolution of that restraining order or where we go from here.

So who wishes to speak first and give me an update?

MR. CURLIANO: Your Honor, Jason Curliano.

Counsel and I had a chance to speak before the hearing this morning. I think, through some mutual cooperation, discussions we have had this morning -- and I'll let Ms. Snyder provide the Court with the specifics -- the child in this very unfortunate case is going to be transferred to Spokane.

MS. SNYDER: Yes.

MR. CURLIANO: I have spoken with our treating doctor who testified last time, Dr. Myette. He's going to work in cooperation with not only the transport agency once we get the specifics, but the receiving physician in Spokane. They are going to make sure the child is stable, appropriately transported. It's hoped that that will take place today, possibly tomorrow.

And, again, Ms. Snyder can give more of the specifics. But we had discussed setting a return date for next Wednesday, and the hope is, barring any complications or hiccups, that the matter should be taken care of, and that Kaiser will have provided what the family needs to get the child transported in the next day or two.

THE COURT: Thank you, sir.

Ms. Snyder?

MS. SNYDER: Yes. That's -- that's correct. So we have reached an agreement. Right now we're just waiting to get the cell phone number from the receiving doctor, the head of the PICU unit up at Sacred Heart Hospital in Spokane, and that physician's name is Peter Graves.

There is a life flight that's on standby prepared to transport Israel today. So barring another

emergency, another emergency flight that they have to make, we're hoping to be able to arrange that for today.

THE COURT: Correct me if I am mistaken, then. What I'm hearing is the parties believe they've worked out something that's in the best interest of each of the parties and to the parents.

Just parenthetically, most lawyers will tell you that it's always best for the parties to try to work out something; okay?

MS. FONSECO: Okay.

THE COURT: To use the crass word of settlement, that isn't appropriate here, but, in essence, that's what I'm referring to. It's often best for the parties to work these things out because then things are in your own hands. You control ultimately what happens, and you don't place that control into the hands of someone else. Even if it is something that you may not entirely agree with, at least the control of it is in your hands; okay? So I hope you understand that.

MS. FONSECO: Okay.

MR. STINSON: I do.

THE COURT: And I know full well that Kaiser understands and appreciates that.

So if I'm hearing correctly, you want to continue the restraining order that is in place now

until Wednesday?

MS. SNYDER: Yes, your Honor.

MR. CURLIANO: Yes, your Honor.

THE COURT: And that would be at 9 o'clock in this department, and that would be April 27th, 2016, under all the terms and conditions that were previously indicated in the restraining order of last week, of the April 15th restraining order.

MS. SNYDER: Yes. The only thing that I would say, that if -- if the physicians agree that Israel needs something just to prepare him for transport, that that is something that they would -- that they would discuss and then would not -- whatever they agree on would not be in any way limited by the order that is in place right now.

MR. CURLIANO: I don't foresee any problem with continuation of care and appropriately stabilizing the child. I spoke with Dr. Myette, and he's just waiting for a phone call or number to make the call to the physician in Spokane.

MS. SNYDER: Okay.

THE COURT: All right. Tentatively that appears to be acceptable to the Court. And I say tentatively, because let me broach another issue that, frankly, I have been thinking of, and obviously wanted to discuss

here this morning, and in large part is based upon the opposition that I received last evening from Kaiser as to the continuation of this restraining order, and that is, the Court made arrangements to have county counsel here -- and I see that Mr. Coffman is present on behalf of the county public guardian -- as to whether or not this Court should appoint the Director of the Department of the Public Guardian as a temporary guardian of the person of the minor child.

I want to hear from each of you on that.

MS. SNYDER: Your Honor, we would ask that that not be the case; that -- that the parents would -- would retain their -- their role at this time. We do have a declaration by the parents with regard to the -- the missed appointments that states -- and I'll get that to you, but that states that many of those appointments were rescheduled. There was one medication that was not refilled. It was one steroid medication, and that was because Israel became violently ill when he took that -- that medication. And if you like, you can hear from Israel's mother regarding that. But his parents have signed a declaration to that effect.

THE COURT: That's okay. I'll accept your representations right now.

I am just looking more to -- obviously, you've

touched upon the issue -- when I see what was contained in here on its face, not accepting it as true, but something that is brought before me, not from a true evidentiary perspective, but giving me knowledge of something that needs to be inquired upon as a judge when I see that because it -- it raises, obviously, red flags in my mind and an issue. Are we in a situation akin to Dority at that point? You know. And, of course, I'm referring to the Dority, D-o-r-i-t-y, case, madam reporter. And so that's where I stand.

Yes, sir, Mr. Jones.

MR. JONES: Your Honor, I don't think -- I don't think we're there yet. I mean, in Dority, it had already -- the guardianship had already been put in place --

THE COURT: Right.

MR. JONES: -- and this type of proceeding occurred.

THE COURT: Yes.

MR. JONES: So I think we're a little premature. At this point in time, Israel's parents have full decision-making authority. And to the degree that that's going to be challenged, I think that would be a decision of the public guardian in the state. I don't know if it would be appropriate for Kaiser to chime in

other than reporting what has happened. I don't know that we would take a position at this point that the parents -- adverse to the parents regarding the consent issue.

THE COURT: So if both parties are in agreement right now to continue with the restraining order as indicated here to the date and the time that I've indicated, then at this time I would not be appointing the public guardian.

Mr. Coffman, good morning, sir.

MR. COFFMAN: Good morning.

THE COURT: But what I'm going to do, though, is -- is keep him in touch with these proceedings and ask that you be here on the 27th as well, and ask that you provide your information and -- contact information to counsel for both sides so in the event that something does come up that needs to be brought to the attention of the Court, including appointment, that it will be put immediately back on calendar.

MS. SNYDER: Yes, your Honor.

MR. CURLIANO: Yes, your Honor.

THE COURT: Do you have something for me?

All right. So does it sound like that's where we want to go with this at this time, Ms. Snyder?

MS. SNYDER: Yes, your Honor. Thank you.

THE COURT: Mr. Jones?

MR. JONES: Yes, your Honor.

THE COURT: Now, the issue becomes, then, where I have a restraining order that's in effect until April 27th at 9 o'clock, and you arrange for this transfer to take place, and let's just, for the sake of discussion, say that transfer takes place at 9 o'clock tonight or anytime in between now and then, I still have a restraining order that's in place. And what's the legal effect of that upon Kaiser even if you do release him and -- to continue with the care that I've directed within the restraining order? I need someone to touch upon what you have discussed with respect to that.

MR. CURLIANO: Your Honor, what Kaiser would propose, subject to the Court thinking that this is appropriate, is that the restraining order be modified to state that it dissolves when -- and it could be when the transport -- when the patient is picked up by the transport company and has left the Kaiser facility.

We could also -- another option would be we could immediately report back, advise the Court, and show up the following day so that the TRO could be dissolved in court by your Honor.

THE COURT: That will be difficult to do if that happens tonight given that we are at the weekend. Of

course, included within all of this is how that transfer process is to take place. Is Kaiser obligated to continue to maintain and release the minor child with the mechanical devices that have been employed at this time? Have you talked about all of those sorts of issues and things?

MR. JONES: I've spoke with Dr. Myette, and the assumption -- and I hate using that word, but we were running fairly quickly this morning -- is that the vent and the rest of the equipment that's necessary, including the personnel to take the child, stabilize him, offer the same assistive devices, medications, that that would be done by the transport company.

I think from our perspective, and if the Court would like, if we need to take a little more time to get the phone number of the transport company and put our physician, Kaiser physician, Dr. Myette, in contact with them, I might be able to report back to the Court specifically how this is going to be accomplished.

THE COURT: Here's what I would like, then.

Ms. Snyder, do you have any comments on what Mr. Curliano has just indicated?

MS. SNYDER: No, not at this time.

THE COURT: Here's what I would like, Folks. I think this makes sense. I think you folks need a little

more time this morning to iron out some of these things and to give more informative information that can be couched within an order; okay? With these details. Because I -- I want to make sure that both parties are covered here, that the parents understand who is responsible for the employment of medical and mechanical devices, and to what extent Kaiser is, to what extent Kaiser is absolved or dissolved of any further requirements under the restraining order upon transfer of that. These things still need to be worked out, including the names, as you say, and exactly who would be appropriate for transferring. Because I also don't want to give an order out there that allows Kaiser to transfer in vague terms which would essentially allow anyone to come in and -- and obtain the minor child.

MS. SNYDER: Uh-huh.

THE COURT: So I do want these specifics to be more -- better formalized so that we can prepare an appropriate order here.

MR. JONES: Your Honor -- your Honor, just in my mind, I would think that once the patient is discharged from the hospital would sort of be a point where a restraining order would become just inapplicable or, you know, moot.

THE COURT: Okay. That makes sense. You folks

talk about that, though; okay? And then we'll draft a more formal order, then, after hearing.

How much do you -- how much time do you think you're going to need this morning to do these -- accomplish this?

MR. CURLIANO: Dr. Myette is available as soon as we have the information available.

MS. SNYDER: Yeah. I am just checking to see.

THE COURT: Here's what I am thinking. Let me provide this information to you as well. I have a jury trial -- I have a jury that's coming back at 10:30. I could adjourn that proceeding an hour after that at 11:30 if that's enough time, if you believe --

MS. SNYDER: That should be.

THE COURT: -- in order for you to make these telephone calls, communications, however it is we deal with these things now with all of these cell phones and smart phones and everything. But whatever you need to do and accomplish so that you can get this information for each of your respective clients and get the detailed information presented so that the Court can prepare an appropriate order after hearing.

Does that make sense, or are you going to need more time?

MS. SNYDER: I think that should be sufficient.

So it looks like I've got a call, and I'm hoping that call has information that will allow the doctors to -- to immediately connect with one another.

THE COURT: I want somebody to couch out and to write out in longhand right now the terms that -- the specific terms and details that you agree upon, and each side sign the bottom of it. Longhand is okay. But that way I know and I will accept that each of you have agreed upon those terms, and then I will prepare a more formal order based upon that information I receive.

Fair enough, Ms. Snyder?

MS. SNYDER: Yes, your Honor. Thank you.

THE COURT: Mr. Jones? Mr. Curliano?

MR. JONES: Yes, your Honor.

MR. CURLIANO: Yes, your Honor.

THE COURT: Okay. Let's do that. And let's reconvene at 11:30, then; okay.

MR. CURLIANO: Thank you, your Honor.

MR. JONES: Thank you.

THE COURT: Thank you, Folks.

Mr. Coffman, I -- I'll leave that up to you, having a private discussion with them, and if they think you don't need to be back, that's fine with me; okay? Otherwise we'll see you on the 27th.

MR. COFFMAN: Thank you, your Honor.

THE COURT: Thank you, sir.

MR. STINSON: Thank you, your Honor.

THE COURT: Thank you.

(Another matter heard.)

THE COURT: All right. Calling the matter of the minor child Israel Stinson. Good morning, Folks. If you want to make your way up.

Thank you for your patience this morning as I went over a little bit. Ms. Snyder is present. I note that Ms. Fonseca and Mr. Stinson are not present, though. You're authorized to present the matters here without them being present?

MS. SNYDER: Yes, I am, but they are on their way in.

THE COURT: Okay. On their way, meaning what? Just a few minutes, perhaps?

MS. SNYDER: Yeah. They were right outside the door.

THE COURT: Oh, okay.

MS. SNYDER: We can get started, your Honor.

THE COURT: All right. Mr. Curliano and Mr. Jones here. As I am speaking, I see now that Mr. Stinson and Ms. Fonseca are making their way in now.

Good morning, folks. Come on up. Come on up. Good morning again.

MS. FONSECO: Good morning.

THE COURT: Make yourself comfortable, folks. Thank you.

One thing you folks may have thought of that came to mind. I was reflecting on this as I was -- trust me, I was paying 100 percent attention to the jury trial but reflecting also on this, something that came to mind. You may have already thought of it, and it may just be an issue that we'll decide upon dissolution of the restraining order. And that's the continuing, if any, jurisdiction of the Court or the dismissal of the action as it is that is pending now --

MS. SNYDER: Uh-huh.

THE COURT: -- with the Court. Okay? All right.

Where do we --

MR. JONES: So we attempted to get as much information as possible regarding the logistics of transferring Israel. We have put together sort of a list of conditions and terms that the parties both agree to related to the proper transport and care, and I can go through the terms on the record now, or I can just present them to you on paper form.

THE COURT: Why don't we -- since we have a record, if -- if it isn't extremely lengthy, let's just

go ahead and put it on the record now as well.

MR. JONES: Okay. Shall I read it as it is exactly or --

THE COURT: Sure.

MR. JONES: -- discuss it?

THE COURT: Read it as it is, and we'll also take a copy, and I am going to mark that. What do we have? Two pages?

MR. JONES: Yeah, two pages.

THE COURT: Okay.

MR. JONES: All right.

THE COURT: Right. And both parties' representatives have signed it?

MS. SNYDER: I have not signed it yet.

MR. JONES: She hasn't signed it. Should we do that first?

THE COURT: Sure. That way I know that it's agreed upon.

And what I will do is this will be marked as Court's Exhibit 1. We'll file it, then, rather than mark it as an exhibit. That way -- yes, that way we will retain it.

MR. CURLIANO: Your Honor, can counsel sign as authorized representatives for both of their respective clients?

THE COURT: Yes, sir. That's my understanding, yes.

And, again, this is what you folks are proposing to me. Ultimately my order is going to be according to my judgment, but considering what you folks have thought of here.

All right. Mr. Jones, if you don't mind.

MR. JONES: I will try to go slow.

The parties hereby stipulate and agree as follows:

One, the terms of the restraining order issued on April 15th, 2016, will remain in effect until April 27th, 2016, subject to the conditions below.

Two, the parents of Israel Stinson, Israel, are transferring him to Sacred Heart Medical Center located at 101 West 8th Avenue in Spokane, Washington, hereinafter Sacred Heart; to facilitate this transfer, AirCARE1 has been retained to transport Israel to Sacred Heart. That was three.

Four, AirCARE1 has agreed to transport Israel with at least one nurse and a respiratory therapist to monitor and assist Israel.

Five, Sacred Heart has agreed to admit Israel.

Six, Kaiser Permanente will cooperate and facilitate in the transfer and will take the necessary

steps in the ordinary course to prepare Israel for transport, and transfer care and support to AirCARE1.

Israel's attending physician at Kaiser Roseville will communicate with AirCARE1 to assure they have the proper staff and equipment to transfer Israel. That was six.

Seven, Israel's attending physician at Kaiser Permanente will communicate with the admitting physician at Sacred Heart to facilitate continuous care and to assure Sacred Heart is prepared to received Israel.

And eight, the restraining order will dissolve upon Israel's discharge from Kaiser Permanente Hospital in Roseville. Discharge means the physical exit from the hospital. Kaiser Permanente's legal responsibility for Israel's care and treatment will cease at that time, period.

Are there any other issues that the Court would like addressed?

THE COURT: Okay. And then the parties will return, in any event, on Wednesday, April 27th, at 9 o'clock.

MR. JONES: Correct.

MS. SNYDER: Yes. Umm, I would just like to ask if for some reason the -- the transfer is delayed between now and Wednesday, we would still like the

opportunity -- hopefully that will not -- we'll not have to -- to do this, but to have Dr. Michel Accad examine Israel if he, in fact, is still at Kaiser. He said he could be there as early as Monday, but was not able to -- to be here this past week, so -- and, again, I am not anticipating having to call him. This is just -- just in case.

MR. CURLIANO: Your Honor, hopefully this doesn't become an issue. We received information with the name of Dr. Accad yesterday evening. He's a cardiologist. He has no pediatric specialty. There are issues that we might have about whether or not he's a qualified person to do an examination of the child. So if it becomes an issue, we would -- and I discussed this with counsel. In the off chance it does, we may need to come back up to seek some guidance on the appropriateness for this physician to do the examination.

THE COURT: Well, here's my concern with what I'm hearing right now. What if this transfer can be facilitated, you know, tomorrow? You know, I -- I'm -- maybe I am misunderstanding, but I want to make sure there isn't going to be any unnecessary delay to try to hang --

MS. SNYDER: Absolutely.

THE COURT: -- over until Monday when the best interest of Israel right now is for him to be transferred.

MS. SNYDER: The plan is to transfer him today, so there is a flight on standby for that purpose.

MR. CURLIANO: And I've confirmed with our treating doctor, Dr. Myette. He is in conversation with the transport company and the appointed person, and he advised me that he can facilitate the transport today.

THE COURT: Okay. I'm expecting that that's what will take place, then, barring some unforeseen circumstance on the medical provider's part.

MS. SNYDER: Yes.

THE COURT: Okay. Anything further on behalf of the parents?

MS. SNYDER: Not at this time, your Honor.

MS. FONSECO: No.

THE COURT: All right. Anything further from Kaiser?

MR. JONES: No, your Honor.

THE COURT: Okay. Here's what I will do. I'll draft an order, and if you folks want to be back here at 1:30, I'll have the formal order hopefully drafted up by that time. We will be in session in jury trial, so feel free to just come on in. You are not interrupting;

okay? And we will see -- at least give you an update as to how much longer it might be, but -- so that you'll have the order. I think it's important for you to have that in hand.

And then the last thing is on -- if this transpires the way that you folks are expecting, anticipating, also then we will be, on the 27th, making the determination that this Court would have no further jurisdiction, as well as dismissal of the action.

Is that the intent, Ms. Snyder?

MS. SNYDER: Yes, it is.

THE COURT: And on behalf of Kaiser, gentlemen?

MR. JONES: Yes, it is, your Honor.

THE COURT: Okay. All right, then. Thank you, Folks.

If anything does come up when you get here at 1:30, I'll let you know and we'll see about if we need to include it or if it's already there, presenting it to you, and seeing whether or not you're in agreement. And if not, maybe it's just something I'll do against your agreement. But we'll put anything on the record at that point; okay?

MR. JONES: Thank you, your Honor.

MS. SNYDER: Thank you so much, your Honor.

MR. CURLIANO: Thank you, your Honor.

MS. FONSECO: Thank you, your Honor.

THE COURT: Thank you, folks.

(Matter concluded.)

M.O.A. DEPOSITION REPORTERS
RUTH E. DIEDERICH HUNTER, CSR NO. 4952

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

ISREAL STINSON by and through JONEE FONSECA, his mother, Petitioner, versus UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER - WOMEN AND CHILDREN'S CENTER, Defendants.	Case No. S-CV-0037673 REPORTER'S TRANSCRIPT

STATE OF CALIFORNIA)
) ss
COUNTY OF PLACER)

I, RUTH E. DIEDERICH HUNTER, Certified Shorthand Reporter of the State of California, do hereby certify that the foregoing Pages 1 through 25, inclusive, comprises a true and correct transcript of the proceedings had in the above-entitled matter held on April 22, 2016.

I also certify that portions of the transcript are governed by the provisions of CCP237(a)(2) and that all personal juror identifying information has been redacted.

IN WITNESS WHEREOF, I have subscribed this certificate at Auburn, California, on May 1, 2016.

_____
RUTH E. DIEDERICH HUNTER, CSR
License No. 4952

25

M.O.A. DEPOSITION REPORTERS
RUTH E. DIEDERICH HUNTER, CSR NO. 4952

EXHIBIT F

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF PLACER

ISRAEL STINSON by and through JONEE FONSECA, his mother
Petitioner;
v.
UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER-WOMEN AND CHILDREN'S CENTER,
Respondent

Case No.: S-CV-0037673

ORDER AFTER HEARING

NEXT HEARING:

April 27, 2016
9:00 a.m.
Department 43

Petitioner and applicant Jonee Fonseca has applied for a temporary restraining order directed to Kaiser Permanente Roseville Medical Center—Women and Children's Center concerning medical care and intervention provided to her son Israel Stinson. TRO proceedings were heard April 14 and 15, 2016, and further proceedings were set for April 22, 2016, 9:00 a.m., in Department 43, the Hon. Michael W. Jones, presiding.

At the April 22 hearing, Ms. Fonseca and Nathaniel Stinson, minor's father, appeared with Alexandra Snyder, Esq. Jason J. Curliano, Esq., and Drexwell M. Jones, Esq., appeared for Kaiser Foundation Hospitals. At the

court's request Roger Coffman, Esq., Senior Deputy County Counsel for Placer County was also present, representing the Placer County Public Guardian.

Petitioner and respondent have reached a stipulation concerning the present circumstances and the TRO. The parties' written stipulation, executed by counsel, has been filed.

Adopting the agreement of the parties, the court orders as follows:

(1) Jonee Fonseca and Nathaniel Stinson shall transfer Israel Stinson to Sacred Heart Medical Center, 101 West 8th Avenue, Spokane, Washington, which has agreed to admit Israel;

(2) Transportation of Israel to Sacred Heart shall be by Air Care 1;

(3) Kaiser will cooperate with and facilitate Israel's transfer and will take necessary steps, in the ordinary course, to prepare Israel for transport, and will transfer care and support of Israel to Air Care 1;

(4) Israel's attending physician at Kaiser Roseville will communicate with Air Care 1 to assure they have proper staffing and equipment to transfer Israel;

(5) Israel's attending physician at Kaiser Roseville will communicate with the admitting physician at Sacred Heart to facilitate continuous care and to assure Sacred Heart is prepared to receive Israel;

(6) The restraining order currently in place, which requires that

(a) Kaiser shall continue to provide cardio-pulmonary support to Israel Stinson as is currently being provided;

(b) Kaiser shall provide medications currently administered to Israel; however, physicians or attending staff may adjust medications to the extent possible to maintain Israel's stability, given his present condition;

(c) Kaiser shall continue to provide nutrition to Israel in the manner currently provided to the extent possible to maintain Israel's

stability, given his present condition;

shall continue in effect until and shall automatically dissolve upon the earlier of:

(a) Israel's discharge from Kaiser Permanente Hospital in Roseville; for this purpose, *discharge* means Israel's physical exit from the hospital; or

(b) Wednesday, April 27, 2016, 9:00 a.m.

Kaiser's legal responsibility for Israel's care and treatment will cease when the restraining order dissolves.

(7) This matter is set for further proceedings April 27, 2016, 9:00 a.m., in Department 43. If the restraining order has dissolved pursuant to paragraph (6), *supra*, the court intends to dismiss this action. The parties have stipulated that the court will thereafter have no jurisdiction over minor, petitioner or respondents under this proceeding.

IT IS SO ORDERED.

DATED: April 22, 2016

Hon. Michael W. Jones
Judge of the Superior Court